

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04507

04497

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR			
Ethel			M.	Ainslie	March	15	1968 6:25P M			
3. SEX	4. RACE	S. DATE OF BIRTH			6. AGE (In years last birthday) 75 YRS.					
Female	Caucasian	2/10/1893			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH							
New York	U S A		Prince George's							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly	Prince Geo. General Hosp.			Retired clerk			U S Gov't			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER						
Maryland	Prince Geo.	Landover	NO	3606 St. Johns Place						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Andrew Ainslie				Franc Weber						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 577 58 7498		17. INFORMANT			Address				
Rose P Waring			Landover, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction of left ventricle and										
4109 due to, or as a consequence of interseptum 1 day										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause										
(b) Secondary to Right Coronary Artery Thrombus										
due to, or as a consequence of										
(c) Generalized arteriosclerosis, severe									Indeterminable	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4109 19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Yes.				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (his hospital) attended the deceased from 3/15 , 1968, to 3/15 , 1968, that (I) (we) last saw the deceased alive on March 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Julius Kauffman</i>		DEGREE	ATTENDING PHYS.	X MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)		Julius Kauffman, M. D.			22e. ADDRESS	6501 Landover Rd., Cheverly, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)	(County)	(State)			
Burial	March 18, 1968	Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons	Hyattsville, Md.			DATE MAR 19 1968			<i>Charles J. Geoghegan</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

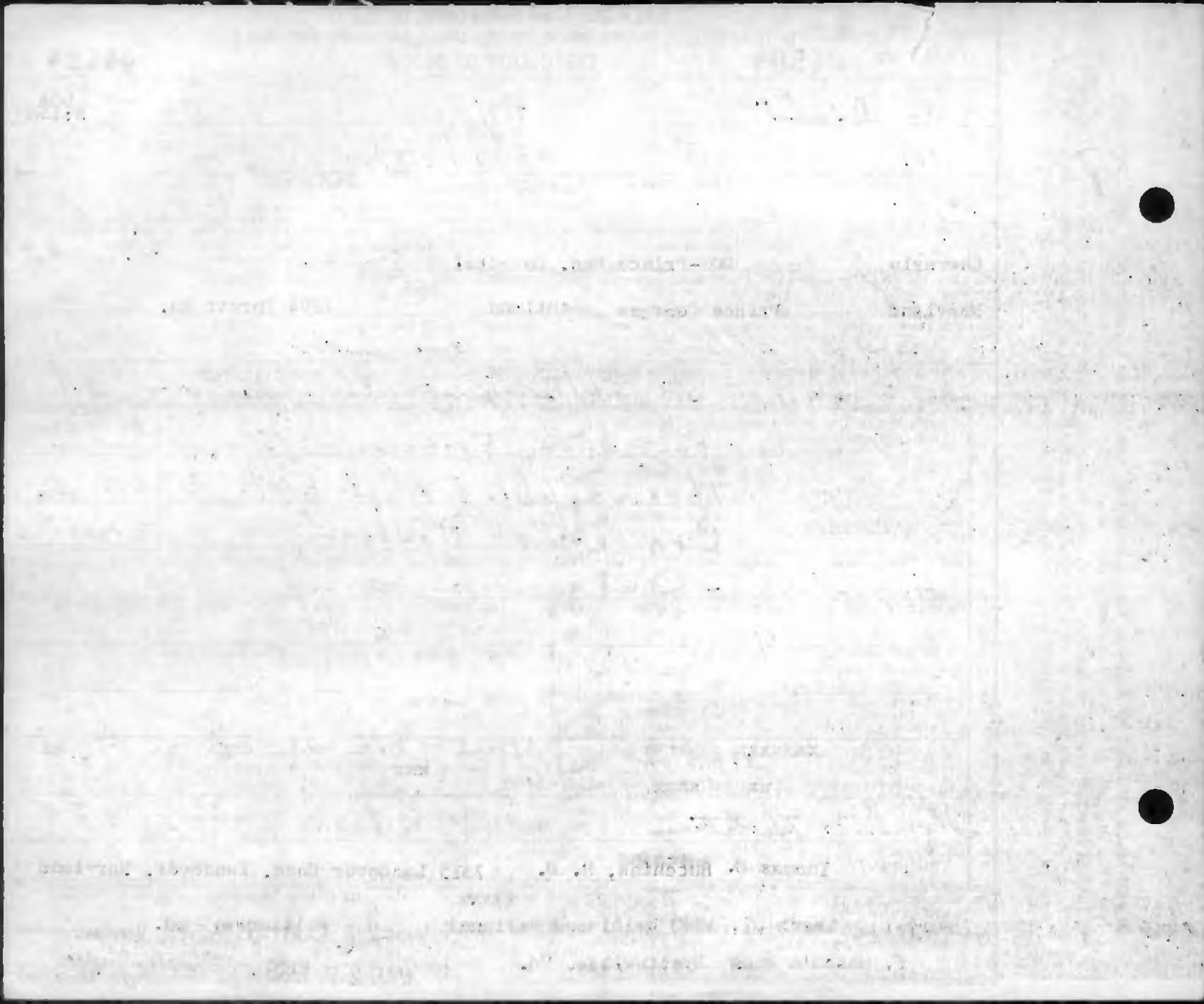
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Item 1 Film G399 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
4/9/68 kk 04498
4/9/68 04498
4/9/68 04498

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR DOA 8:15 A.M.		
Alarie Allen	A	L	Allen	3 25 68			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
m	w	12/27/00	67 yrs.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. COUNTY OF DEATH	10. CITY OR TOWN OF DEATH			
Tra	USA	NEVER MARRIED DIVORCED	Prince Georges	Cheverly			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
DOA-Prince Geo. Hospital	truck driver	millwork					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland	Prince Georges	Kentland		7204 Forest Rd.			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
Lang L. allen				Jane Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
WWII	578-03-1263	alyce m allen Kentland, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus							
185 X DUE TO, OR AS A CONSEQUENCE OF							
(b) Thrombophlebitis, Left Leg 6 weeks.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 177x							
DUE TO, OR AS A CONSEQUENCE OF							
(c) Canceroma of Prostate 3 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
Hypertensive Cardiovascular Disease							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (physician) attended the deceased from March 1968, to March 1968, that (I) (was) lost saw the deceased alive on March 1968, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.							
22b. SIGNATURE	Thomas M. Hutchins	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED	3-25-68
22d. PHYSICIAN'S NAME (Type)	Thomas M. Hutchins, M. D.	22e. ADDRESS	7315 Landover Road, Landover, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR Crematory	23d. LOCATION (City or Town)	(County)	(State)		
Burial	March 27, 1968	Baltimore National	MAR 27 Baltimore	Md.			
24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons	Hyattsville, Md.	MAR 27 1968	Charles Judge				
VR A15 (4) 30M REV. 1/68							



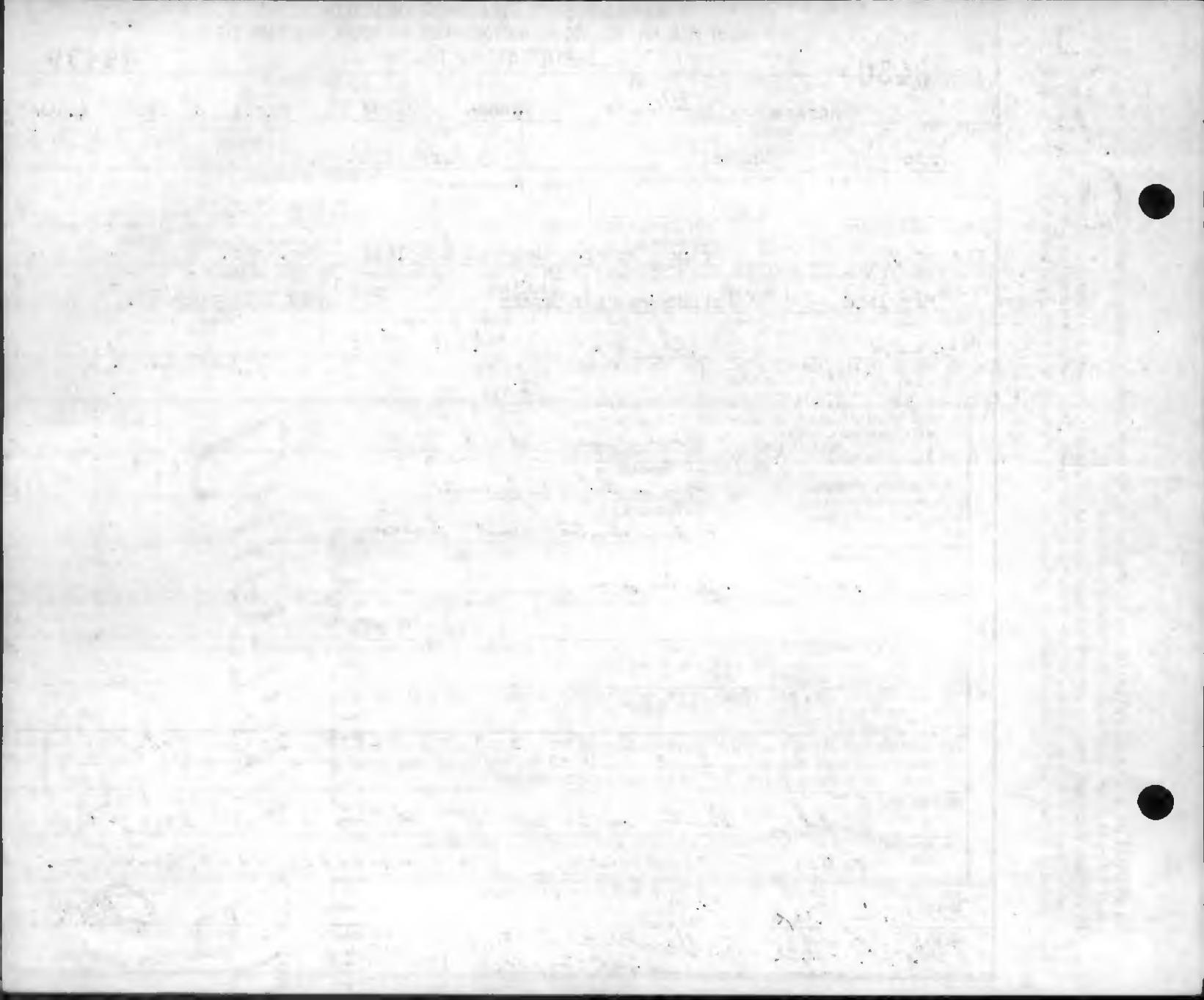
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Horace	Middle Willis	Last BROWN ALLEN	2a. DATE OF DEATH Month Mar., Day 10 1968 Year 4:00 A.M.	2b. HOUR 4:00 A.M.	
3. SEX Male		4. RACE White		S. DATE OF BIRTH 13 March 1916	6. AGE (In years last birthday) 51 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ter. Mgr.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9889 Telegraph Rd.		
14. FATHER'S NAME Rohlen		First Allen	Middle Allen	Last Allen	15. MOTHER'S MAIDEN NAME MARIE ROSE	Middle Allen	Last Allen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause last. (c) <u>Atherosclerotic heart disease</u>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201 Essential hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>If either, notify medical examiner</small>		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>3-9</u> , 19 <u>68</u> , to <u>3-10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-10</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Fidel J. Quintana M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>3-10-68</u>		
22d. PHYSICIAN'S NAME (Type) <i>FIDEL J. QUINTANA</i>		22e. ADDRESS <u>12004 MAYCHECK LANE, BOWIE, MD.</u>					
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE <u>Mar 13, 1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>LAKEVIEW CEMETERY STRATFORD</u>		23d. LOCATION (City or Town) <u>CONN.</u>	(County) <u>CONN.</u> (State)
24. FUNERAL DIRECTOR <i>John J. Kelly</i>		ADDRESS <u>550 WASHINGTON BLVD.</u>		25a. REC'D. BY REGISTRAR <u>Charles J. Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	DATE <u>MAR 21 1968</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Baby	Middle Bay	Last Averys	2a. DATE OF DEATH Month Mar. Day 3 Year 68	2b. HOUR 1.45 P.M.
3. SEX Male	4. RACE White			S. DATE OF BIRTH 2 March 1968	6. AGE (In years last birthday) YRS. - 13	IF UNDER 1 YEAR MONTHS - DAYS - HOURS - MIN 13
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges	Md.	
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prin. Geo. Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3313 Darlington St.		
14. FATHER'S NAME First Charles Everett Averys	Middle	Last	15. MOTHER'S MAIDEN NAME First Barbara Ruth Wright	Middle	Address	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 7720	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 1300 grams						
DUE TO, OR AS A CONSEQUENCE OF (b) Atelectasis of both lungs.						
DUE TO, OR AS A CONSEQUENCE OF (c) Subarachnoid Hemorrhage of right parieto-occipital lobe of cerebrum.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 760.5						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED At home <input type="checkbox"/> At work <input type="checkbox"/> Not white <input type="checkbox"/> Not black <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 6400 Marlboro Pike , City or Town Dist. Hights, Maryland	County	State	
22a. I certify that (1) was born attended the deceased from March 2, 1968 to March 3, 1968 , that (1) was last seen the deceased alive on March 3, 1968 , and that in my opinion death occurred on the date and hour and from the causes stated above, (1) did not view the body after death.						
22b. SIGNATURE <i>Charles A. Parker, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED March 6, 1968			
22d. PHYSICIAN'S NAME (Type) Charles A. Parker, M.D.		22e. ADDRESS 6400 Marlboro Pike, Dist. Hights, Maryland				
23a. BURIAL, CREMATION, REMOVAL/REMOVAL	23b. DATE 3/16/68	23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. General Hosp.	23d. LOCATION (City or Town) Cheverly, Maryland	(County)	(State)	
24. FUNERAL DIRECTOR <i>William A. Parker, Assoc. Administrator</i>	ADDRESS	25a. REC'D BY REGISTRAR DA	25b. REGISTRAR'S SIGNATURE <i>Charles J. Parker</i>			

17
Date Given: 10/10/01
Name: ANDREW LEE
Address: 12345 12th Street
City: NEW YORK
State: NY
Zip: 10001
Phone: (212) 555-1234
Email: andrew.lee@nyc.gov

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

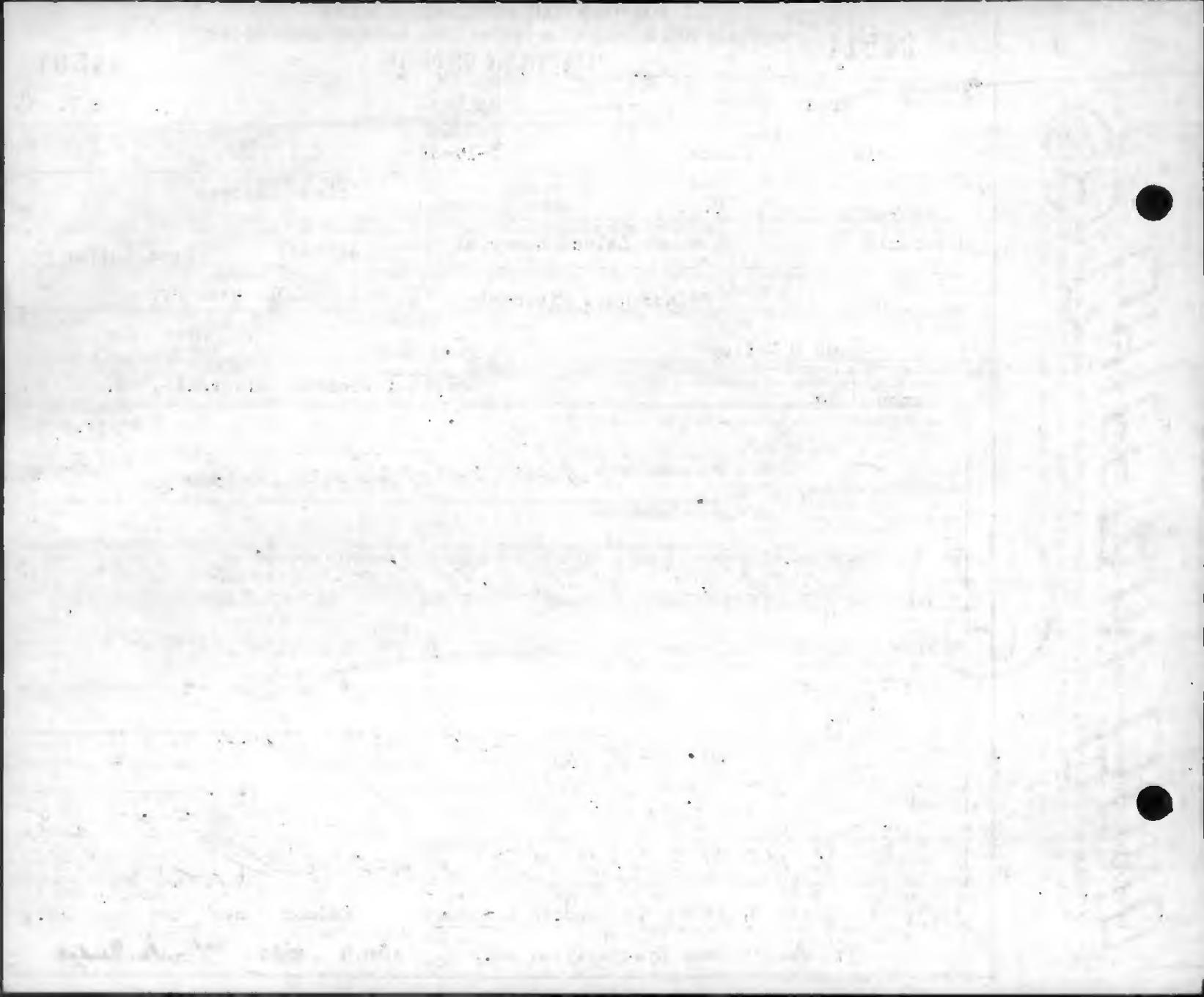
04511

04501

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Fred	Middle -	Lost Bailey	2d. DATE OF DEATH Month 3 Day 31 Year 68	2b. HOUR 7:30 A.M.	
3. SEX Male		4. RACE White		S. DATE OF BIRTH 8-18-81	6. AGE (In years lost by date of death) 88 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial		12e. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) (Retired)		12b. KIND OF BUSINESS OR INDUSTRY Meat cutter	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6101 44th Pl.	
14. FATHER'S NAME Jacob D Bailey		First Middle Lost		15. MOTHER'S MAIDEN NAME First Mary Gage			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown united		16b. SOCIAL SECURITY NO. No		17. INFORMANT Hospital records		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Uremia General arterio sclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo underlying	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4500 Gastric ulcer with hemorrhage.							
19a. DATE OF OPERATION 2/2		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 7/27/67, to 10/23/68, that (I) (we) last saw the deceased alive on 10/23/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L W Malin MD		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-31-68.		
22d. PHYSICIAN'S NAME (Type) L W MALIN MD		22e. ADDRESS Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 3, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Mt Lincoln Cemetery		23d. LOCATION (City or Town) Colmar	(County) Flemington	(State) Md.
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR APR 9 1968	25b. REGISTRAR'S SIGNATURE W. L. Malin, Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

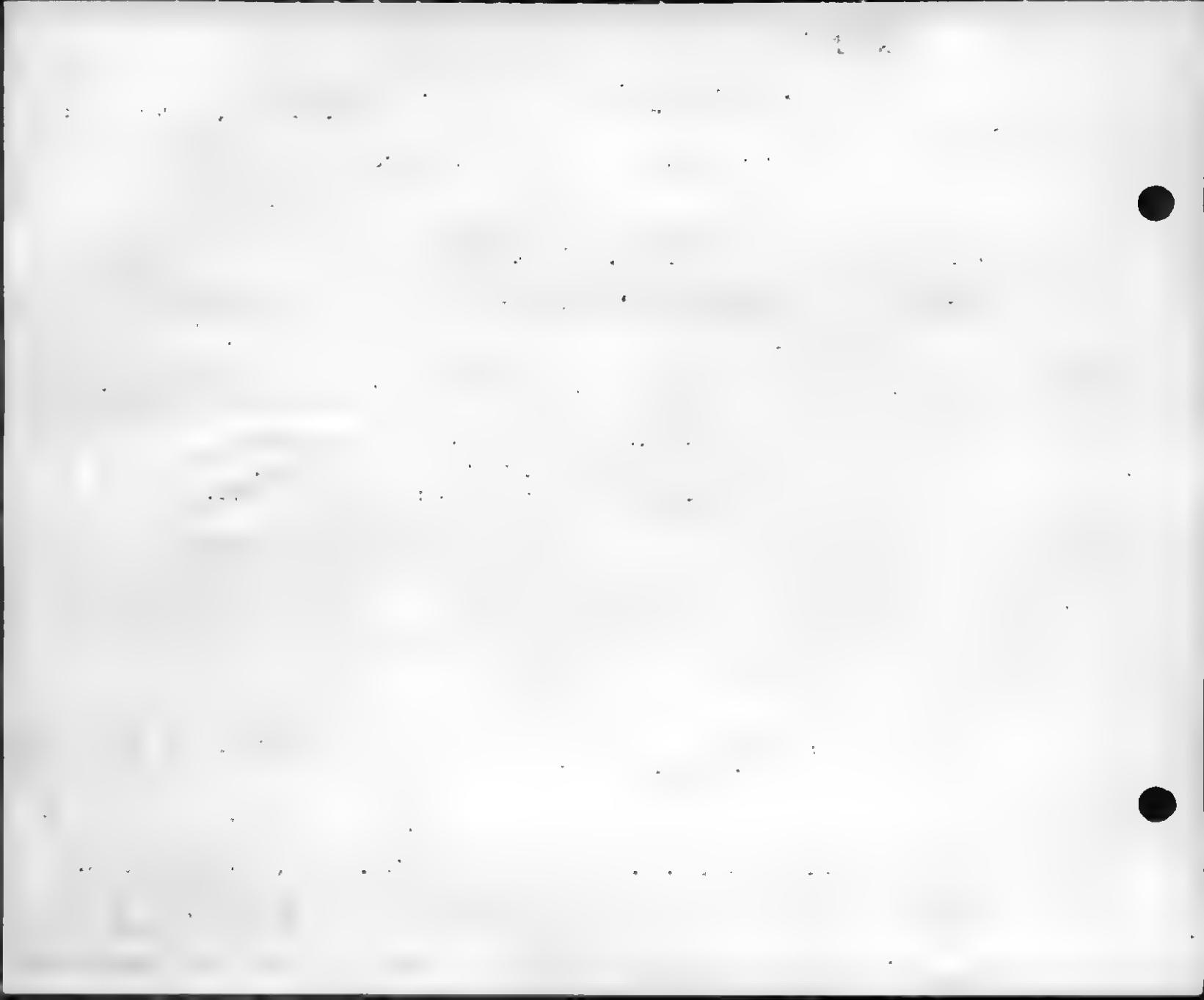
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, attach it to the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, creation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Film G398 3/18/68 kk

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	Mary First E. Baker Sister	Middle Sometimes known as Gertrude Baker	2a. DATE OF DEATH Month Day Year March 5, 1968	2b. HOUR 9:30 P.M.
3. SEX Female	4. RACE Caucasian	S. DATE OF BIRTH May 22, 1882/1881	6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges	12b. KIND OF BUSINESS OR INDUSTRY School
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher	13e. STREET AND NUMBER 5300 43rd Avenue	12b. KIND OF BUSINESS OR INDUSTRY School
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland	13b. CITY OR TOWN Prince George's	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Hyattsville	13f. ADDRESS Hyattsville, Md.
14. FATHER'S NAME First Middle Lost William P. Baker	15. MOTHER'S MAIDEN NAME First Middle Lost Frances Fitzgerald			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 218 54 6432	17. INFORMANT Margaret C Walsh	Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the tail of the Pancreas with metastasis to the Liver. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Thrombo-embolus; right upper lobe. DUE TO, OR AS A CONSEQUENCE OF (c)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that (I) <input type="checkbox"/> attended the deceased from Feb 7, 1968 , to March 5, 1968 , that (I) <input type="checkbox"/> last saw the deceased alive on March 5, 1968 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death.				
22b. SIGNATURE <i>John Deitz</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-6-68
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.		22e. ADDRESS Prince Geo. Plaza, Hyattsville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 9, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Notre Dame Reading Cemetery	23d. LOCATION (City or Town) Hamilton	(County) Butler (State) Ohio
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR Charles J. Deitz	25b. REGISTRAR'S SIGNATURE Charles J. Deitz	DATE MAR 11 1968



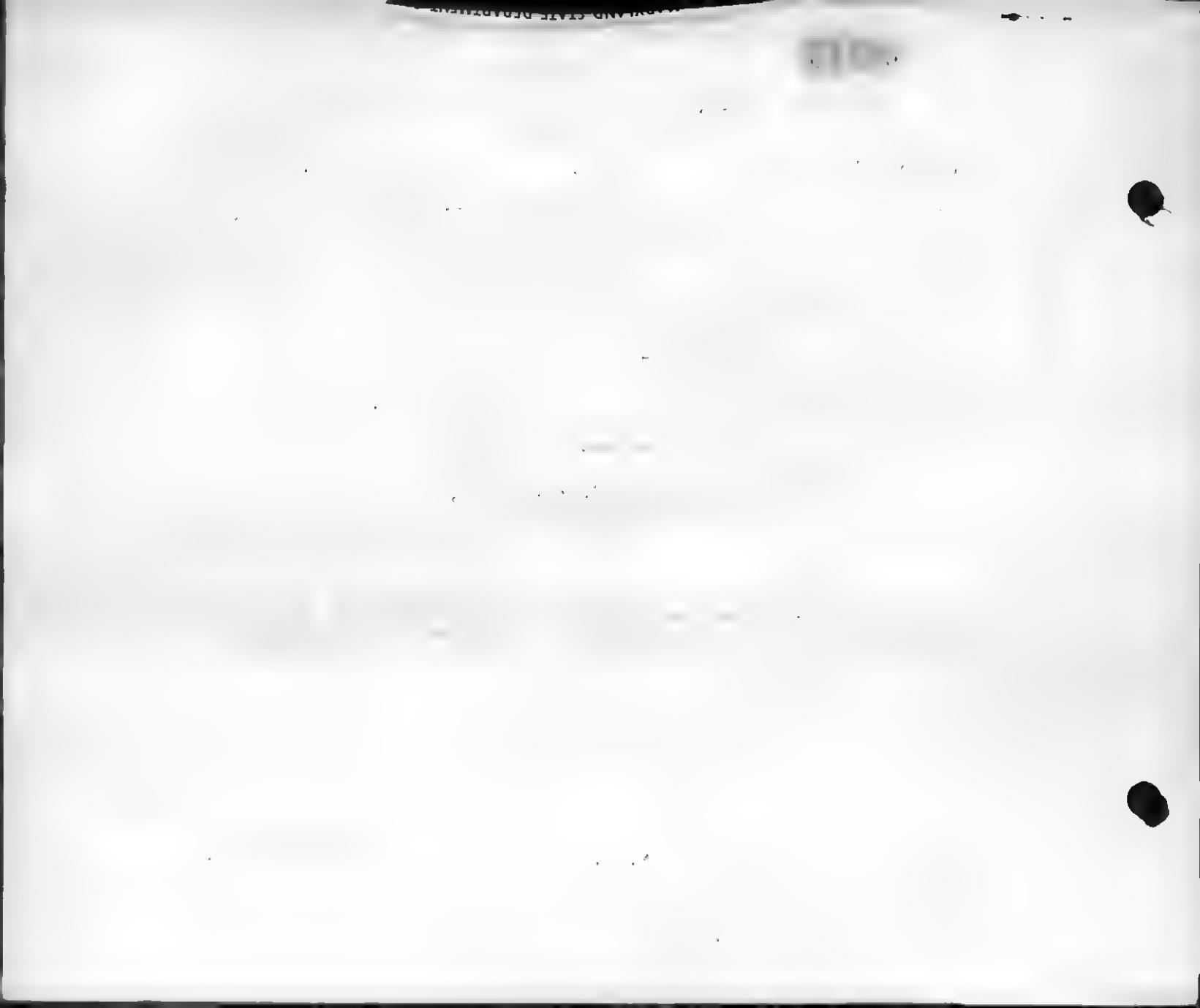
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carb₃ papers. ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Washington, D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1166 Neal St., N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith		First R.	Middle Banks	4. DATE OF DEATH 3 12 19 68	Month 3	Day 12	Year 19 68
S SEX F	6. COLOR OR RACE N	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/21/1906	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Saxton, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dorsey Holmes							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right lung, with wide-spread metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 1621 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON G.VEN IN PART I (o) Generalized arteriosclerosis cerebrovascular accident with right hemiparesis; left radical mastectomy for carcinoma of the breast, 1940 INTERVAL BETWEEN ONSET AND DEATH 1 month							
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/8/1966, to 3/12/1968 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/12/1968, and that death occurred at 8:30PM, from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss, M. D.				22b. DATE SIGNED 3/12/68			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL/CREMATION, (Specify)		23b. DATE THEREOF 3-16-1968	23c. NAME OF CEMETERY OR CREMATORIALy Harmony Mem Pk		23d. LOCATION (City or Town) Lanover	(County)	(State) Md.
24. FUNERAL DIRECTOR W.W. Chambers Chapin St. D.C.		ADDRESS Washington	25a. REC'D BY REGISTRAR DATE MAR 15 1968		25b. REGISTRAR'S SIGNATURE Glenn		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 20. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			Middle			Last			2a DATE KNOWN <input type="checkbox"/> Month Day Year								
George Robert Barnes									2b HOUR								
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR			IF UNDER 24 HRS			2c DATE PRONOUNCED DEAD							
Male	White	3-7-1942	26 yrs	MONTHS	DAYS	HOURS	MIN	Month	Day	Year	2d HOUR						
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH							
Kentucky		USA								Prince George's Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. S.U.A. OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly				Prince George Hospital				13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
								Maryland				Prince George		Yes <input type="checkbox"/> No <input type="checkbox"/>		5674 Alice Ave., Apt. 101	
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last	Geneva Harpe			
Raymond L. Barnes, Sr.																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
				(If yes give war or dates of service)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Gun shot wound of chest																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)									
				7:01 PM 3-11-1968				Shot self while cleaning gun.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County		State	
				home								same as # 13					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>John Kehoe</i>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
												ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City or Town)				(County)		(State)			
Burial		3/15/68		Cedar Hill Cemetery				Suitland, Maryland									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STAR				25b. REGISTRAR'S SIGNATURE									
Carroll Clark		Dominion Funeral Home, Alexandria, Va.						MAR 18 1968									

201



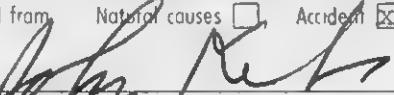
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First James	Middle H	Last Barnes	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3-2-68	Month Day Year 19 1 1968	2b. HOUR 19 1 40am M
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 5-24-1944	6. AGE (in years last birthday) 23	7. IF UNDER 1 YEAR MONTHS YRS	8. IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3	Day 2	Year 1968
7a. BIRTHPLACE (State or foreign country) Washington DC USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George Hospital			12a. JURAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a. JURAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE New York			13b. CITY OR TOWN COUNTY New York City Bronx			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Hardy			Middle Barmes			15. MOTHER'S MAIDEN NAME First		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO 074 348 987			17. INFORMANT U. S. Army Records ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock X160 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause just (b) _____ DO TO, OR AS A CONSEQUENCE OF (c) _____ Laceration of neck APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:40am 3-2- 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car which struck bridge abutment					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office, bus, etc.) Balt. Wash. Parkway at Rt. 193 overpass., Prince George Co., Md.			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) John Kehoe MD Riverdale, Md.			22b. DATE SIGNED 3-3-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 7 ' 68	23c. NAME OF CEMETERY OR CREMATORIAL Long Island National			23d. LOCATION (City or Town) Farmingdale (County) New York (State)		
24. FUNERAL DIRECTOR Howard County Fun. Home Harry Witzke		25a. ADDRESS Elliot City Maryland			25b. REC'D. BY REGISTRAR DATE APR 12 1968 F. J. JONES, JUDGE			

442

a

B — b

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

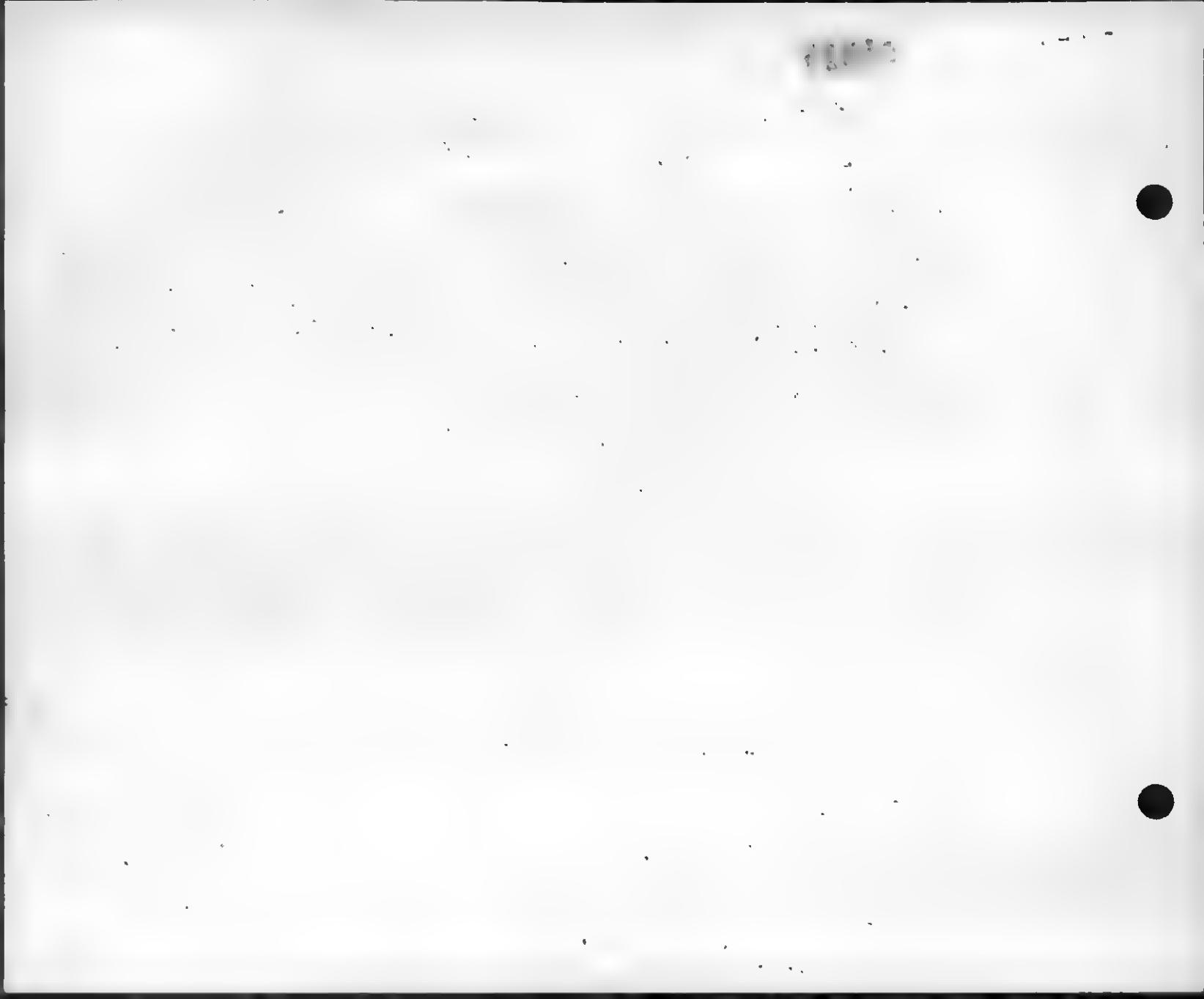
04516

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Flora</i>	Middle <i>M</i>	Last <i>BEACH</i>	2a. DATE OF DEATH Month <i>Mar</i>	Day <i>2</i>	Year <i>68</i>	2b. HOUR <i>6A M</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>3/26/1874</i>		6. AGE (In years last birthday) <i>93</i>		IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	IF UNDER 24 HRS. MINUTES <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>PRINCE GEORGES</i>					
10. CITY OR TOWN OF DEATH <i>Hyattsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hyattsville Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>REIDENT MA.R.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>APT. HOUSE</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>—</i>		13c. CITY OR TOWN <i>Wash</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>1954 Cal Rd N.W.</i>			
14. FATHER'S NAME <i>William J Hutchinson</i>		First <i>William</i>	Middle <i>J</i>	Last <i>Hutchinson</i>	15. MOTHER'S MAIDEN NAME <i>AMELIA</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (Unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>HYATTSVILLE N.H. Records</i>		Address <i>Hyattsville N.H. Records</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>month</i>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>coronary occlux</i></p> <p>due to, or as a consequence of</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>artery occlusion due to disease</i></p> <p>(b) <i>artery occlusion due to disease</i></p> <p>due to, or as a consequence of</p> <p>(c) <i>artery occlusion due to disease</i></p>											
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 1st, 1968</i> to <i>Mar 2, 1968</i>, that (I) (we) last saw the deceased alive on <i>Feb 27, 1968</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>											
22b. SIGNATURE <i>Till Bergmann</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Mar 2nd 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Till BERGMANN</i>		22e. ADDRESS <i>Greenbelt Corp Building Greenbelt Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 5, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>WASH. D.C.</i>					
24. FUNERAL DIRECTOR <i>W. W. Chambers</i>		ADDRESS <i>2025 Clifton St. N.W. Wash. D.C.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE MAR 5 1968			



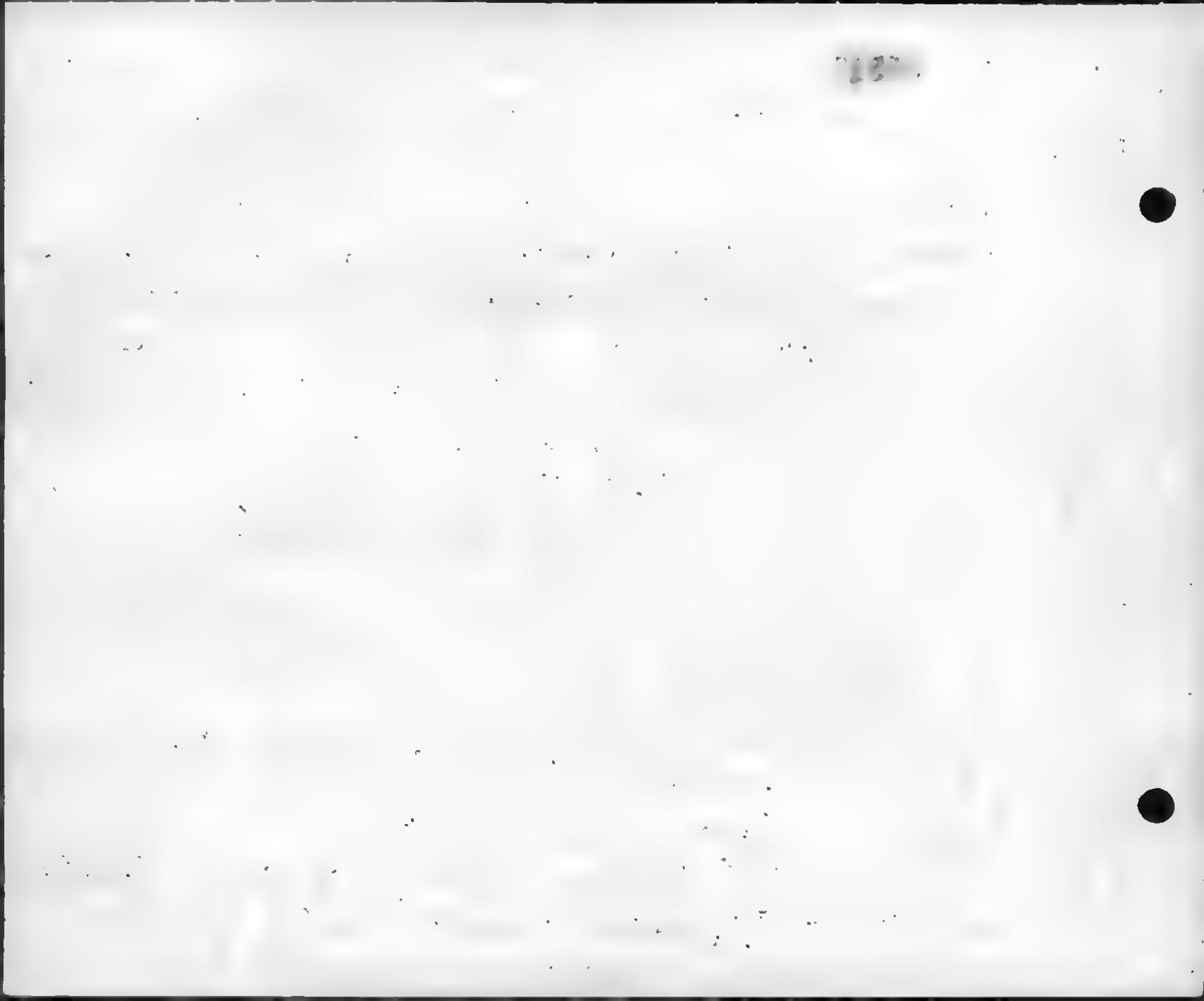
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

DECEASED NAME (Type or print)		First Jeanette	Middle XXXX	Last BEALE	2a DATE OF DEATH Month March Day 23 Year 1968	2b HOUR M
3 SEX F	4. RACE W	5. DATE OF BIRTH 2-8-1903		6. AGE (in years last birthday) 65	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George		12b KIND OF BUSINESS OR INDUSTRY At Home	
10 CITY OR TOWN OF DEATH Greenbelt		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) + Convalescent Ctr		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY PG	13c CITY OR TOWN Boltsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 31222 Evans Trail		
14. FATHER'S NAME JOHN	Middle Crawford	15 MOTHER'S MAIDEN NAME - First LILLY			Middle Fairchild	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or <u>Det. down</u>	16b. SOCIAL SECURITY NO	17. INFORMANT RICHARD A BEALE GROVLAND, SON RD GENESSEE NY		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		Approximate interval between onset and death 3 weeks				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d INJURY OCCURRED Wh. to <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from <u>10 Janus 1968</u> , to <u>23 March 1968</u> , that (I) (we) last saw the deceased alive on <u>7 March 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Seraph T. Kimball</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>Mar 27 1968</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>9801 Georgia Avenue, Silver Spring</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE <u>3/27/68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>PACIFIC VIEW MEMORIAL</u>	23d. LOCATION (City or Town) <u>NEWPORT BEACH</u>	(County) <u>CALIF.</u>	(State)
24 FUNERAL DIRECTOR <u>W.W. CHAMBERS</u>		ADDRESS <u>1400 Chapin St., N.W. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	DATE <u>Mar 27 1968</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04518

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First James	Middle Bernard	Lost Beall Jr.	2d. DATE OF DEATH Month March	Day 23,	2b. HOUR 1968		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov 4, 1915	6. AGE (In years lost birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General D.O.A		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY retail			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN New Carrollton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6007 84th Avenue			
14. FATHER'S NAME First James B. Beall Sr.		Middle 	Lost 	15. MOTHER'S MAIDEN NAME First Mildred Ritchie	Middle 	Lost 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 720-16-6958		17. INFORMANT Catherine H. Beall	Address see # 13				
18. CAUSE OF DEATH (Enter only one cause per line 18a, (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 		Coronary Thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease								2 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 16, 1965 , to Mar 22, 1968 , that (I) (we) last saw the deceased alive on Mar 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William D. Rosson MD		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/23/68					
22d. PHYSICIAN'S NAME (Type) William D. Rosson MD		22e. ADDRESS 5701 85th Av., Hyattsville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/26/68		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City or Town) Bladensburg, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Jos. Gawler's Sons		ADDRESS 5130 Wisconsin Av., Wash. D.C.		25a. REC'D BY REGISTRAR DATE MAR 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

273

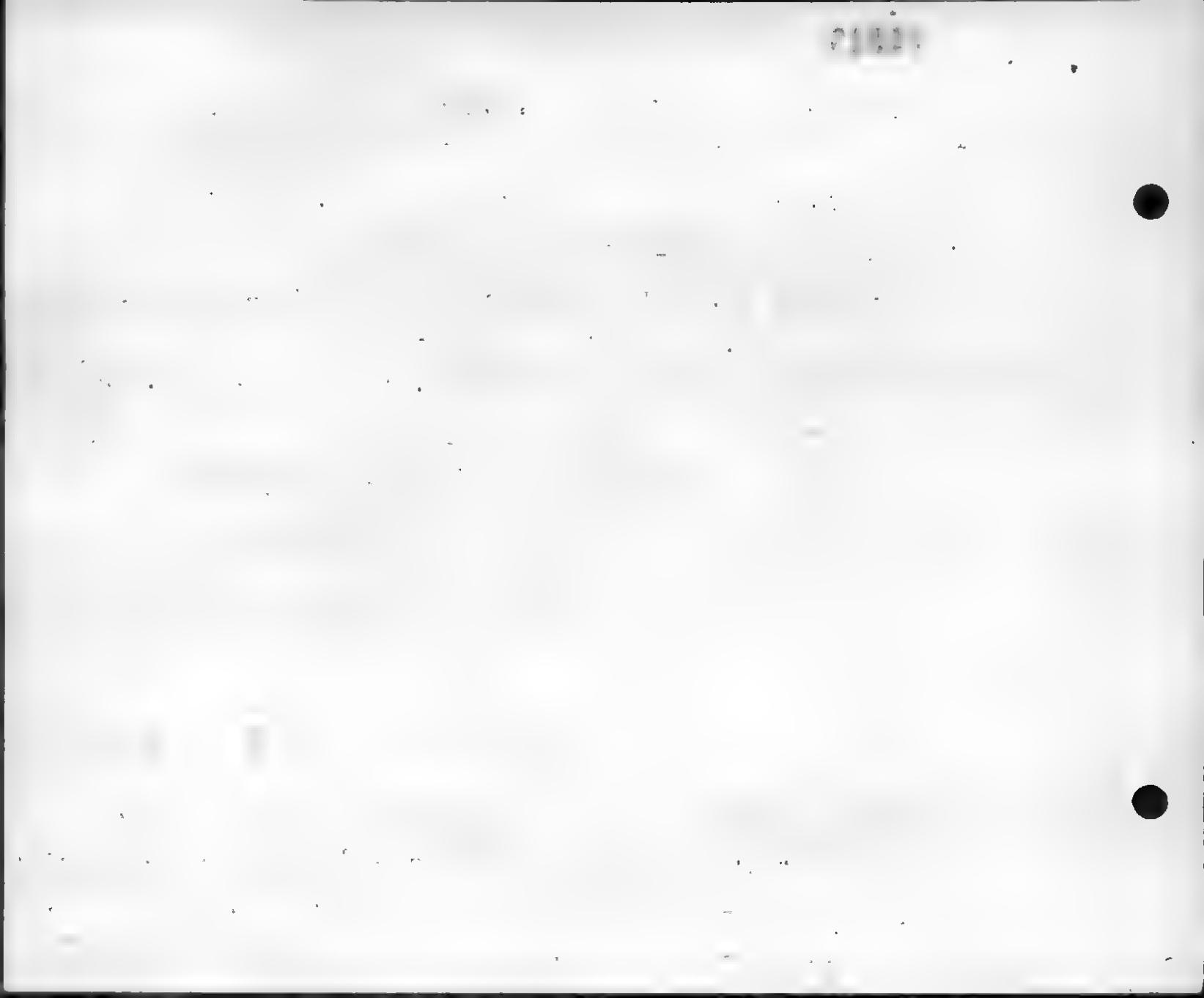


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Beverly	Middle E.	Last Beard	2a. DATE OF DEATH Month March	Day 27	Year 1968	2b. HOUR 1:50 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 17-1880		6. AGE (In years last birthday) 87		IF UNDER 1 YEAR 87 YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Pr. George's			
10. CITY OR TOWN OF DEATH College Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5205- Palco Place		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY USA			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Fr. Geo's		13c. INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER 5205- Palco Place			
14. FATHER'S NAME First Davie		Middle H.	Last East	15. MOTHER'S MAIDEN NAME First Margaret McCray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Louis B. Clark - 5014- 26th. Ave., SE		Address Md.			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)</p> <p>PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Stroke</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hyperension Cardiovascular Disease</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) 3-4 years</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) 3-4 years</p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>4201</p>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION 4/20/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 41		City or Town 1968		County 1968	
<p>22a. I certify that (I) (this hospital) attended the deceased from 3/1/68, to 3/1/68, that (I) (we) last saw the deceased alive on 3/1/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE Thomas F. Cullen		22c. DATE SIGNED 3/27/68							
22d. PHYSICIAN'S NAME (Type) Thomas F. Cullen		22e. ADDRESS 5103- Marlboro Pike, Hillside, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 30-68		23c. NAME OF CEMETERY OR CREMATORIAL New Providence Presbyterian Cem. Raphine, Va.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Simmons Bros. 1661-Gd. Hope Rd. SE. DC		ADDRESS Wash		25a. REC'D BY REGISTRAR APR 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

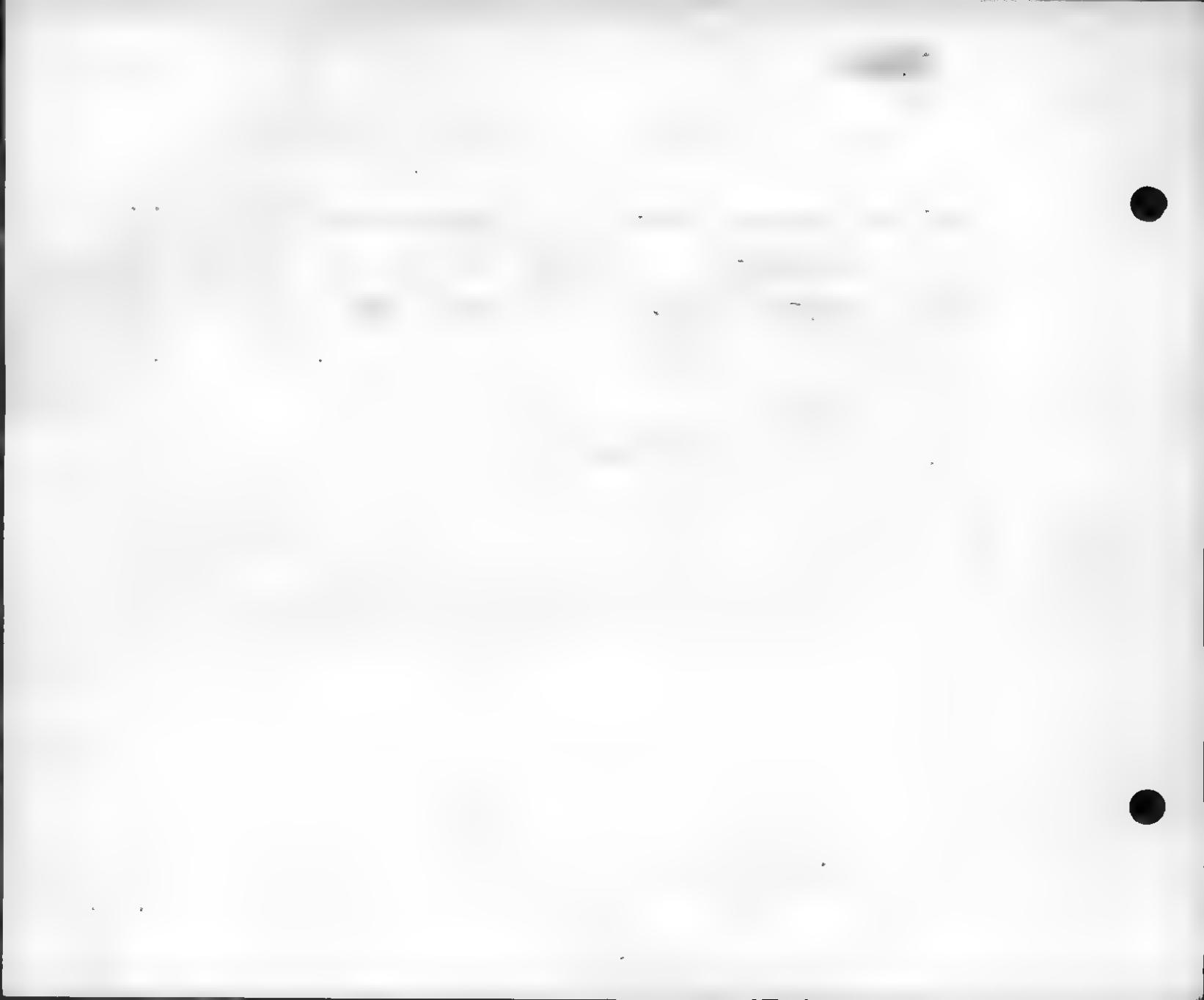


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH																					
1 PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>District of Col.</i> - - - b. COUNTY <i>Washington</i> ✓																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ayattsville</i>				c LENGTH OF STAY IN TB				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Ayattsville Nursing Home</i>				d STREET ADDRESS <i>6500 3145 Beach Street, N.W.</i>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3 NAME OF DECEASED (Type or print)		F _f	Middle <i>Sophie</i>	lost	4 DATE OF DEATH	Month <i>MARCH</i>	Day <i>6</i>	Year <i>1968</i>													
5 SEX <i>FEMALE</i>		6 COLOR OR RACE <i>WHITE</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>July 24, 1886</i>				9 AGE (In years last birthday) <i>81 yrs</i>		10 IF UNDER 1 YEAR Months <i>0</i>	11 IF UNDER 24 HRS Hours <i>0</i>	12 MIN <i>0</i>									
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b KIND OF BUSINESS OR INDUSTRY <i>- - -</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>				12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>George L. Brandt</i>				14. MOTHER'S MAIDEN NAME <i>Marie Heinemann</i>				15. SOCIAL SECURITY NO <i>579-60-0920</i>				16. INFORMANT <i>Mrs. Valerie B. Rohland - See Item #2</i>									
17. ADDRESS																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>												INTERVAL BETWEEN ONSET AND DEATH <i>at Death</i>									
if : Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				DUE TO (b) <i>Acute Coronary Thrombosis</i>								preceding death immediately									
				DUE TO (c) <i>Arteriosclerotic Heart Disease</i>								Several years									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)				20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>68</i> , to <i>March 6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>March 4</i> , 19 <i>68</i> , and that death occurred at <i>7:55 AM</i> , from causes and on the date stated above.																22b. DATE SIGNED <i>3-6-68</i>					
22a. SIGNATURE <i>Stuart L. Nelson</i>								M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>													
22c. PHYSICIAN'S NAME (Type) <i>Dr. Stuart L. Nelson</i>				22d. ADDRESS <i>831 University Blvd East Silver Spring Md</i>				23d. LOCATION (City or Town) <i>Prince Georges Co. Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>3-9-1968</i>				23c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>				23d. LOCATION (City or Town) <i>Prince Georges Co. Md.</i>									
24. FUNERAL DIRECTOR <i>Joseph Lawler's Sons Inc.</i>				ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. D.C.</i>				25a. RECEIVED BY REGISTRAR DATE <i>MAR 8 1968</i>				25b. REGISTRAR'S SIGNATURE <i>James J. Lawler</i>									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

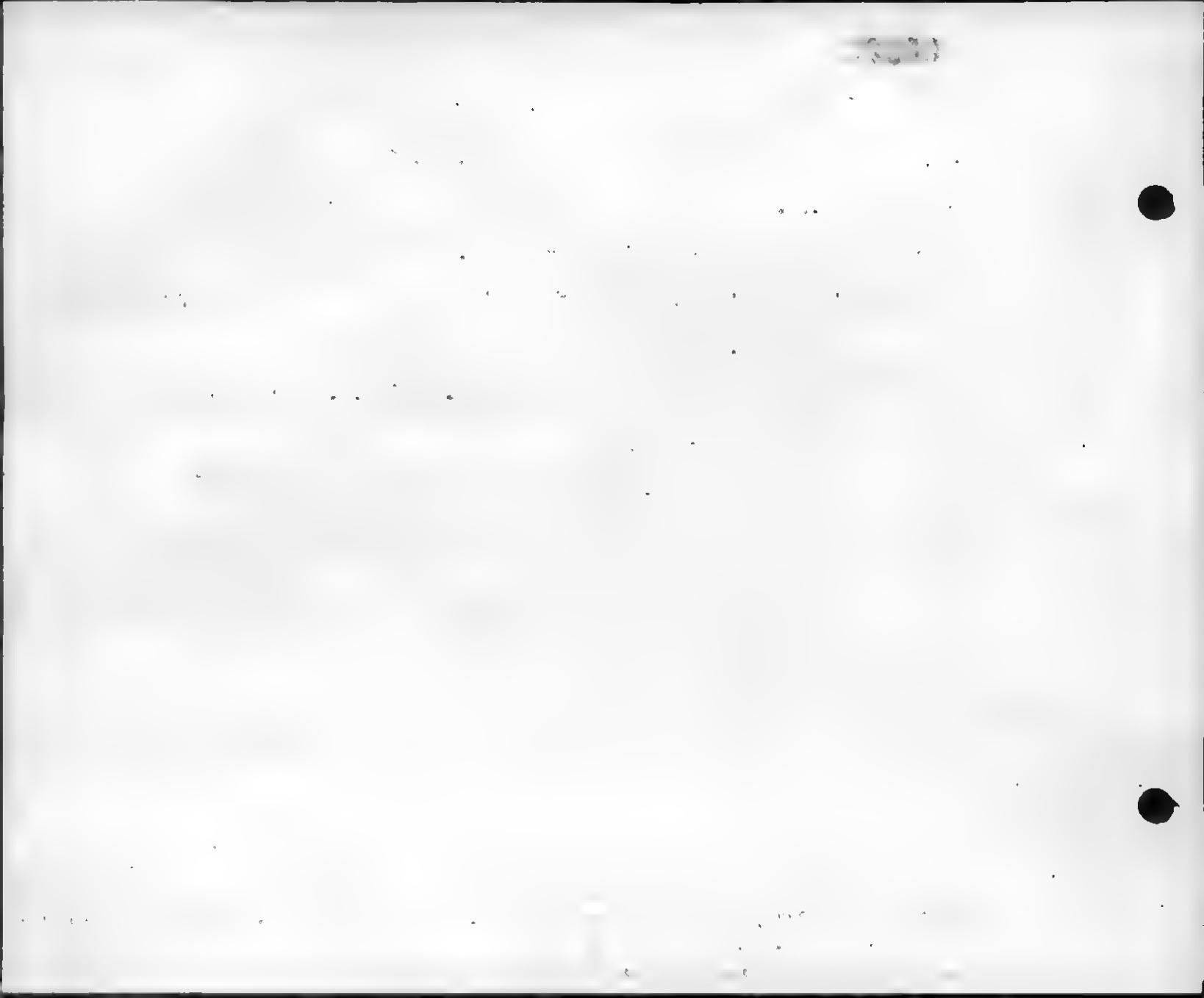
CERTIFICATE OF DEATH

04521

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. If either, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

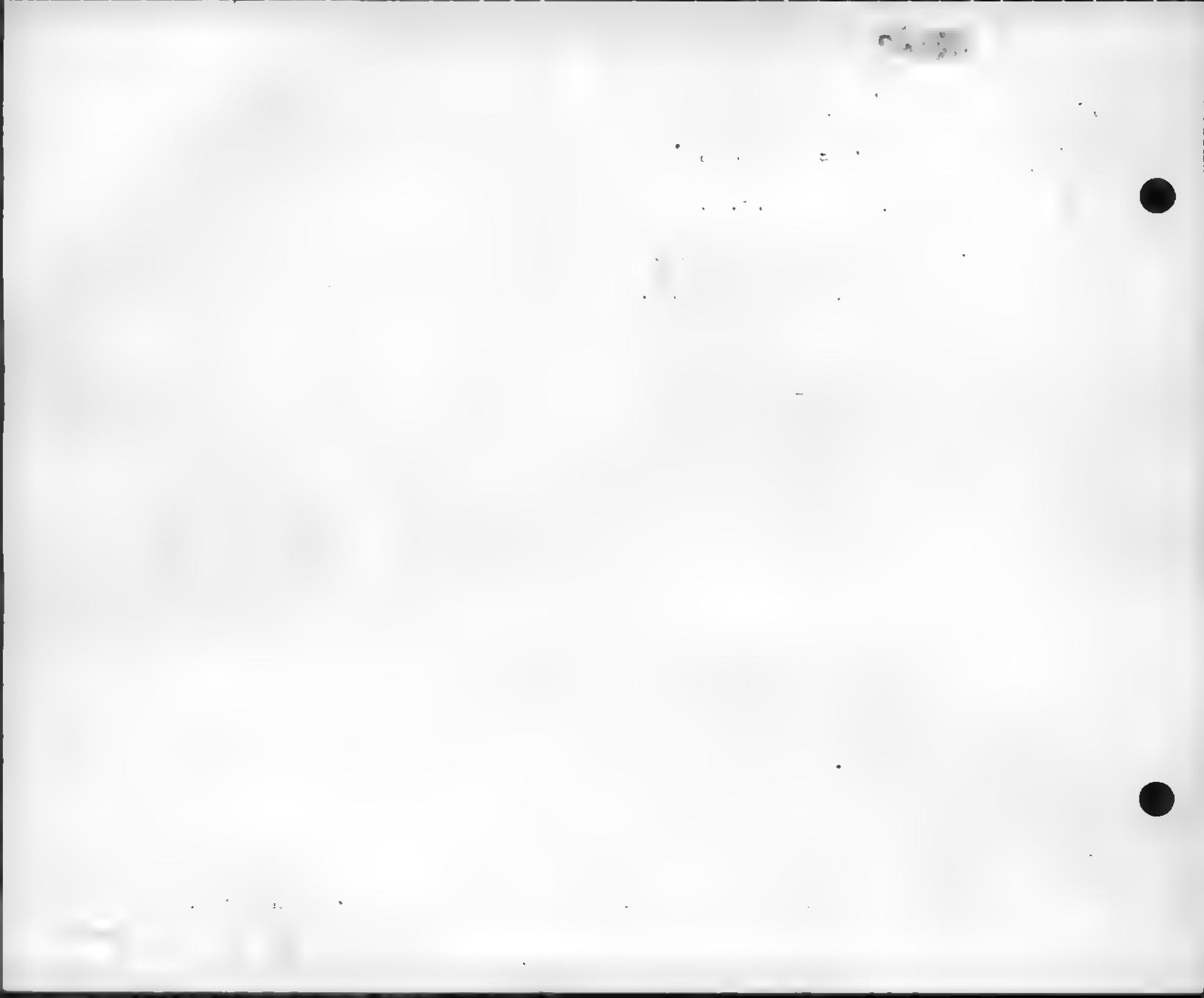
1. DECEASED NAME (Type or print)		First KAREN	Middle SUE	Last BELLO	2a DATE OF DEATH MARCH 14 1968	2b HOUR 6 A M	
3. SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH NOV. 12, 1948	6 AGE (In years last birthday) 19 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges	
10. CITY OR TOWN OF DEATH District Heights		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3116 Wintergreen Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Md	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN District Heights	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3116 Wintergreen Avenue	
14. FATHER'S NAME First Charles H. Echterling		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Betty Filling		Middle 	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 		17. INFORMANT John J. Bello Jr.		Address Same As # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hearted Carcinomotor						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 175g		DUE TO, OR AS A CONSEQUENCE OF (b) Osteoarthritis. Carcinoma right knee,					
		DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 17							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 161	City of Town Bethesda	County Prince Georges	State Md.
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1967 , to Mar. 14 1968 , that (I) (we) last saw the deceased alive on Mar. 14 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Benjamin S. Pecon		DEGREE PHYS	ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Mar. 21 1968			
22d. PHYSICIAN'S NAME (Type) Benjamin S. Pecon		22e. ADDRESS 6106 Old Belts Rd. Ross					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/16/68		23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery		23d. LOCATION (City or Town) (County) (State) Clinton, Prince Georges, Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home				25a. REC'D BY REGISTRAR Charles J. Johnson		25b. REGISTRAR'S SIGNATURE Charles J. Johnson	
				DATE MAR 21 1968			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3 to MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH ESTI- MATED		Month	Day	Year	2b HOUR	
FELIX BENN				BENN	<input checked="" type="checkbox"/>	3	29	1968	M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years less birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	9 DEATH MATED	2c DATE PRONONCED DEAD Month Day Year			2d HOUR	
Male	White	Aug. 8, 1907	60 YRS				March	29	1968	M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Penn.		U. S. A.				Prince George					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDSTRY					
Cheverly		Hospital Prince George General		Painter		Building					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY & MTS?		13e STREET AND NUMBER					
Md.		P.G. Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5235 Kennilworth Avenue					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
		John		Benn	Cecelia				Teck		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
Yes 1921-1925				Pearl Benn Same as #13 (wife)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4109</u> <u>Coronary fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Coronary arteriosclerosis</u> (c) DUE TO, OR AS A CONSEQUENCE OF											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>											
19c DATE OF OPERATION		19d CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<u>Dayton O. Watkins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <u>3-29-68</u>			
23a BURIAL CREMATION, Burial REMOVAL (Specify)		23b DATE 4/1/68		23c NAME OF CEMETERY OR Crematory Mt. Olivet		23d LOCATION (City or Town) Washington D.C.		(County) (State)			
24. FUNERAL DIRECTOR		ADDRESS		25a RECEIVED BY REGISTRAR APR 1- 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Francis Gasch's Sons Hyattsville, Md.											



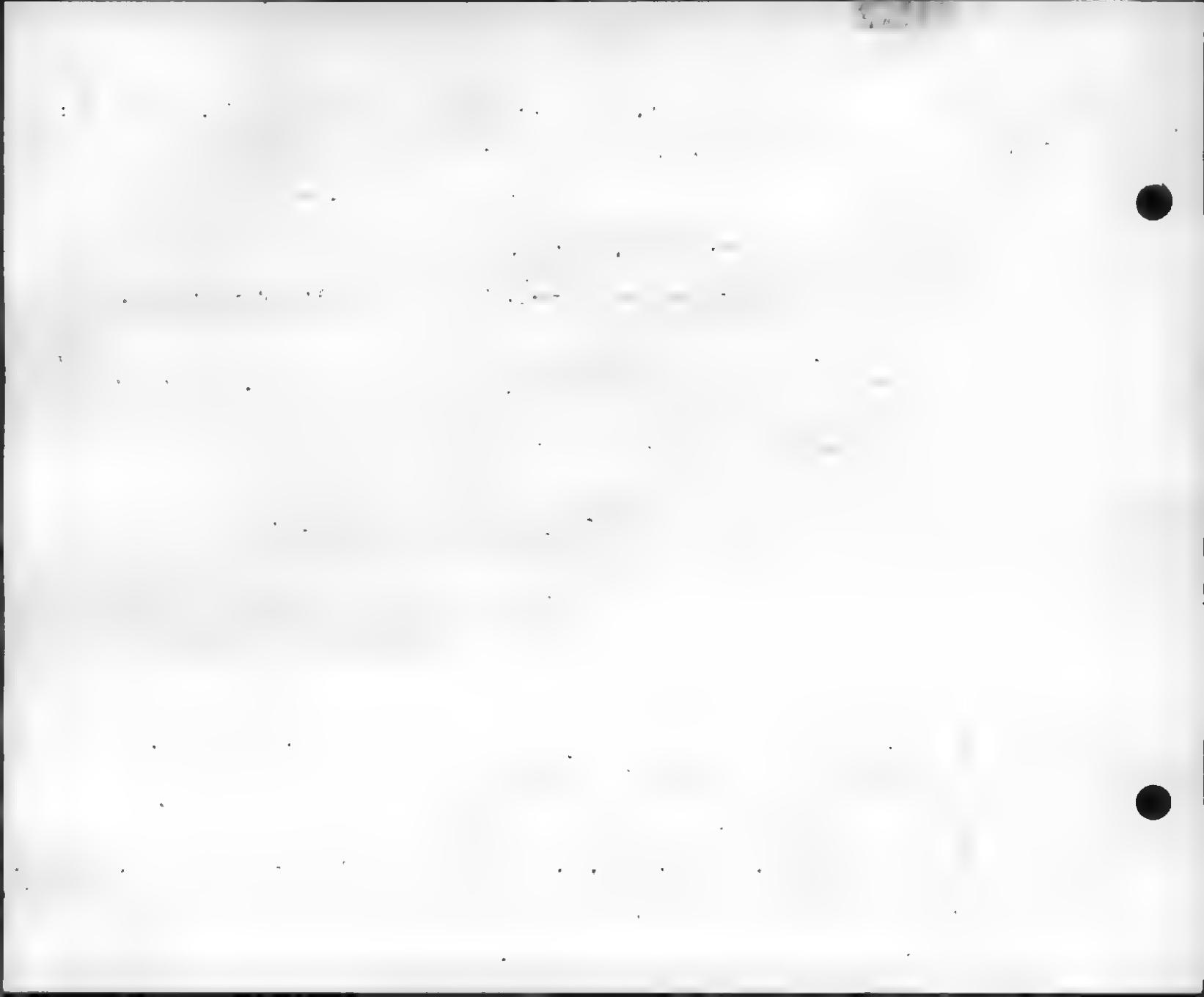
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 6, 7a & 7b Film G399 3/28/68

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First Saul	Middle F.	Last Berman	2a. DATE OF DEATH Month March	Day 20, 1968	2b. HOUR 10:45 A.M.		
3. SEX Male	4 RACE Caucasian	5. DATE OF BIRTH 3/12/89		6. AGE (In years last birthday) 78 79 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN 0	
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges				
10. MARRIED Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or private address) Prince Geo. Gen'l Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland	13c. CITY OR TOWN Prince Georges	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9294 Edmonston Rd.					
14. FATHER'S NAME First Abraham	Middle Berman	15. MOTHER'S MAIDEN NAME First Anna	Address 2747 N. Yucatan St Arlington, Va.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 114-12-5781	17. INFORMANT Avron Berman (son)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic cardiac Heart Disease								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420.1								
19a. DATE OF OPERATION 4/20/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 5, 1968 , to March 20, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.								
22b. SIGNATURE Hernandez		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 3/20, 68		
22d. PHYSICIAN'S NAME (Type) Tomas J. Hernandez, M. D.		22e. ADDRESS Prince Georges General Hospital, Cheverly,						
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE March 22, 1968	23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden		23d. LOCATION (City or Town) Falls Church, Virginia	(County) Maryland		
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS 232 Carroll St., N.W. Wash., D.C.	25a. REC'D BY REGISTRAR 6 MAR 26 1968	25b. REGISTRAR'S SIGNATURE Charles J. Judge				
VR A15 (4) 30M REV. 1/68								



FOR STATE
HEALTH DEPT.

34526
1, 2, and 3 to
PM3. Page
the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form
5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2d DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2d HOUR
James Austin				Billings	3-16-68	19	uni known		
3. SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)	7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		
Male	White	12-16-1924		43 yrs	MONTHS	DAYS	HOURS	MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/>	9 COUNTY OF DEATH				
Washington D C		U S A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Prince George's				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KND OF BUSINESS OR INDUSTRY	
Seabrook		9300 Vaughn Place			Mechanic			Automobile	
13a USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN	13d. INSIDE CITY & MTS?		13e STREET AND NUMBER		
Maryland		Prince George		Seabrook	YES <input type="checkbox"/>	NO <input type="checkbox"/>	9300 Vaughn Place		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
George Billings					Harriet Parker				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS			
yes 1942-1945		578 22 0598		Genevieve L. Billings		Seabrook, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Subdural hemorrhage									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c)									
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		unknown 19		unknown					
22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town	County	State	
		unknown		unknown					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22b. DATE SIGNED 3-21-68
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) John Kehoe MD Riverdale, Md.							
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE March 22, 1968		23c NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d LOCATION (City or Town) Colmar Manor Pro Geo Md.		(County) (State)	
24 FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

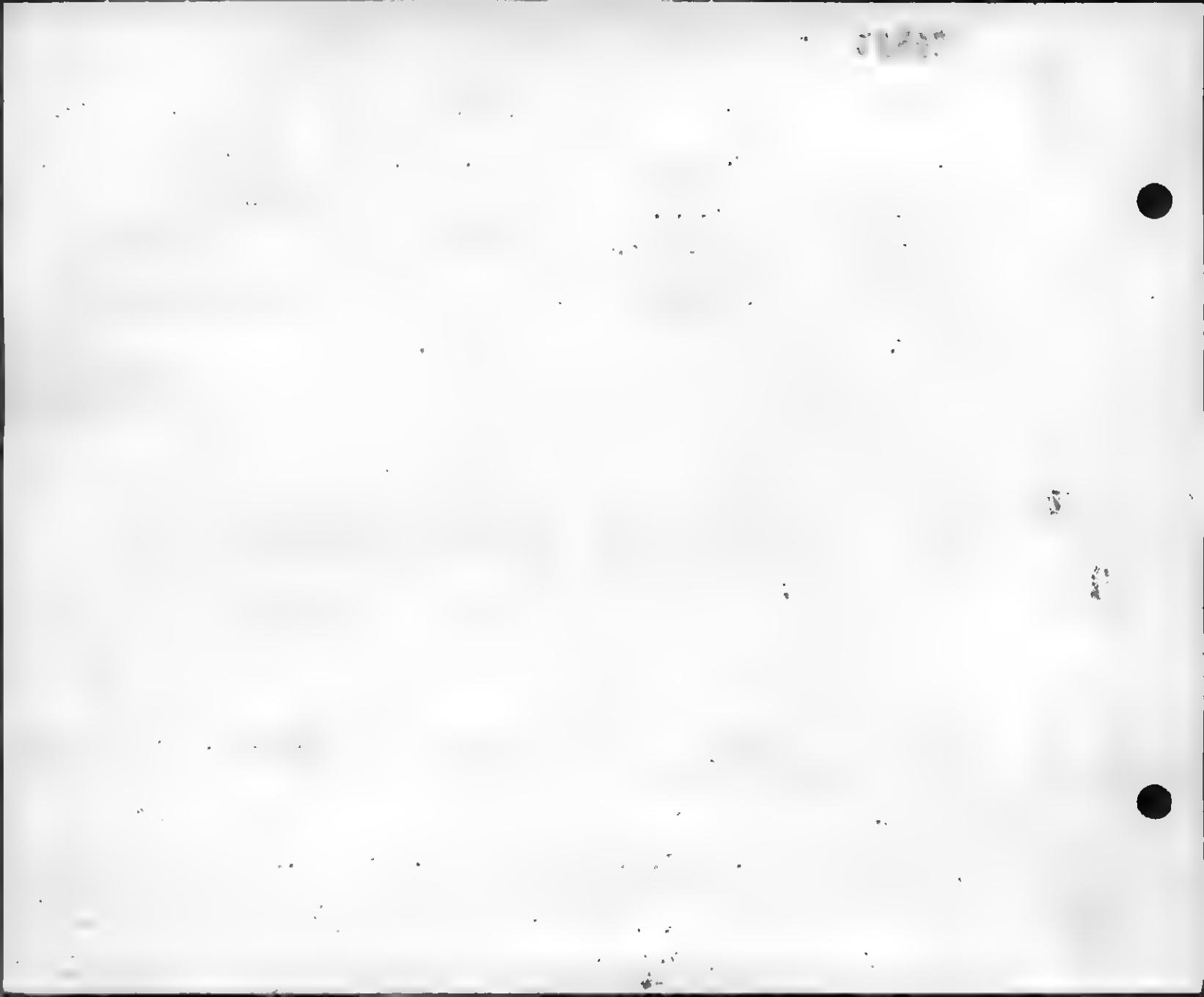


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Baby	Middle Boy	Last Bokoles	2a. DATE OF DEATH Month March Day 28 , Year 1968	2b. HOUR 9:30AM	
3. SEX Male		4 RACE Caucasian	5 DATE OF BIRTH March 28, 1968		6 AGE (In years last birthday) YRS. 40	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince Georges			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) Prince Geo. Gen'l Hospital		12a JSJAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13c CITY OR TOWN Bowie	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12406 Rustic Hill Drive			
14. FATHER'S NAME John M. Bokoles		15. MOTHER'S MAIDEN NAME Judith A. Bee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO. (If yes give war or dates of service)	17 INFORMANT	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hydrocephalus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from March 28, 1968 , to March 28, 1968 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on March 28, 1968 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>James E. Abell</i>		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-28-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 6001 Landover Rd., Cheverly, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/13/68	23c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hosp.	23d. LOCATION (City or Town) Cheverly, Maryland	(County)	(State)	
24. FUNERAL DIRECTOR <i>HARRY W. PEIN</i>		ADDRESS HARRY W. PEIN, JR. ADMINISTRATOR	25a. REC'D BY REGISTRAR APR 17 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

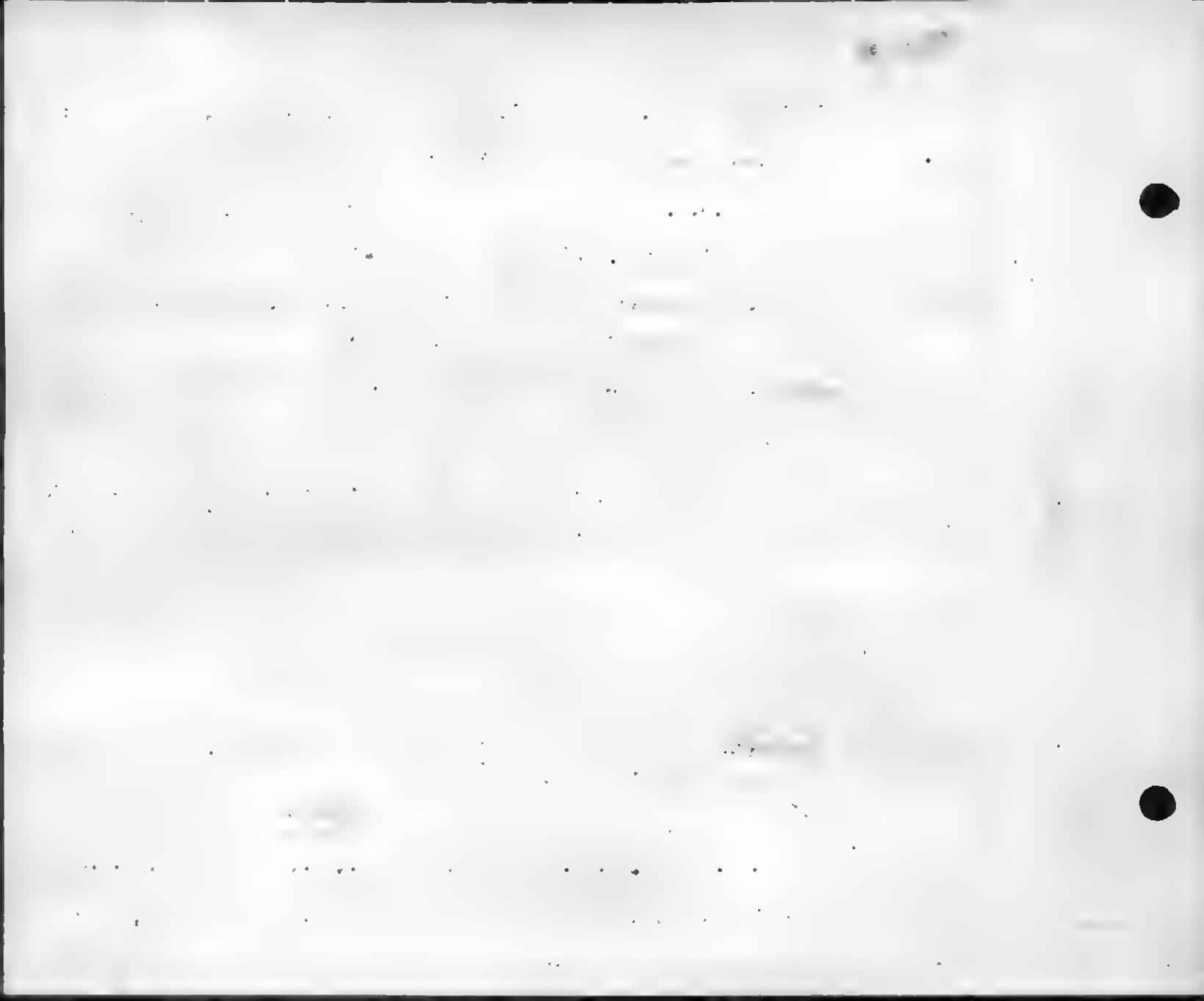
J451

04528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Benjamin	Middle M.	Last Bolinger	2a. DATE OF DEATH Month March	Doy 6	Year 1968	2b. HOUR 9:30 P.M.
3 SEX Male	4 RACE Caucasian	S. DATE OF BIRTH 11/2/08	6. AGE (In years lost birthday) 59	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS DAYS HOURS	MIN MIN	
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH Prince Georges	Md			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>						
10. CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pharmacological Firm	12b. KIND OF BUSINESS OR INDUSTRY Firm				
13a. USUAL RES.DENCE (Where deceased lived, if institution: Res.dence before admission) STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN University Pk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6413 Adelphi Road			
14 FATHER'S NAME First Benjamin	Middle W	Last Bolinger	15 MOTHER'S MA DEN NAME First Betty Smith	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <input checked="" type="checkbox"/> No	16b. SOCIAL SECURITY NO. 212.01 7988	17 INFORMANT Pauline H Bolinger	Address University Park, Md	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anuria							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) Metastatic cancer retroperitoneal space							
DUE TO, OR AS A CONSEQUENCE OF (c) Primary cancer of lung							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22o. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from July , 19 63 , to March 6, 1968 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on March 6, 1968 , and that in my (<input checked="" type="checkbox"/> my) (<input type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>John H. E. Bayly</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED March 6, 1968			
22d. PHYSICIAN'S NAME (Type) John H. E. Bayly, M. D.	22e. ADDRESS 1835 Eye St., NW, Washington, D.C. 20006						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 9, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill Cemetery	23d. LOCATION (City or Town) Washington D. C.	(County)	(State)		
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE MAR 11 1968	25b. REGISTRAR'S SIGNATURE <i>James J. Gasch</i>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certifcate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN <input type="checkbox"/> Month Day Year			2b HOUR		
HARLEY			L.	BOOTHE		ESTI- DEATH MATED	<input checked="" type="checkbox"/>	3-9-68	1968	10:00pm	
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Male	White	10-17-1922	45 yrs					3	10	68 19	9:30am
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH				
Virginia		U.S.					Prince George's			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a JSUA OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Upper Marlboro			Plummers Atlantic Station			Attendant			Gas Station		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Maryland			Prince George			YES <input type="checkbox"/> NO <input type="checkbox"/>			Plummers Atlantic Station		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Madison			Boothe			Nancy			Bishop		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
Yes			WWII			Dolly B. Terrell Sister			Radford, Virginia		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Acute intoxication-thyl alcohol											
DUE TO, OR AS A CONSEQUENCE OF											
39 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
									YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	
21a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Kehoe</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED 3-11-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.											
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE 3/25/68			23c NAME OF CEMETERY OR CREMATORIAL WHITE ROCK CEMETERY			23d LOCATION (City or Town) FLOYD COUNTY		
24 FUNERAL DIRECTOR F. GASCH'S SONS			ADDRESS HYATTSVILLE, MARYLAND			25a REC'D BY REGISTRAR MAR 26 1968			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

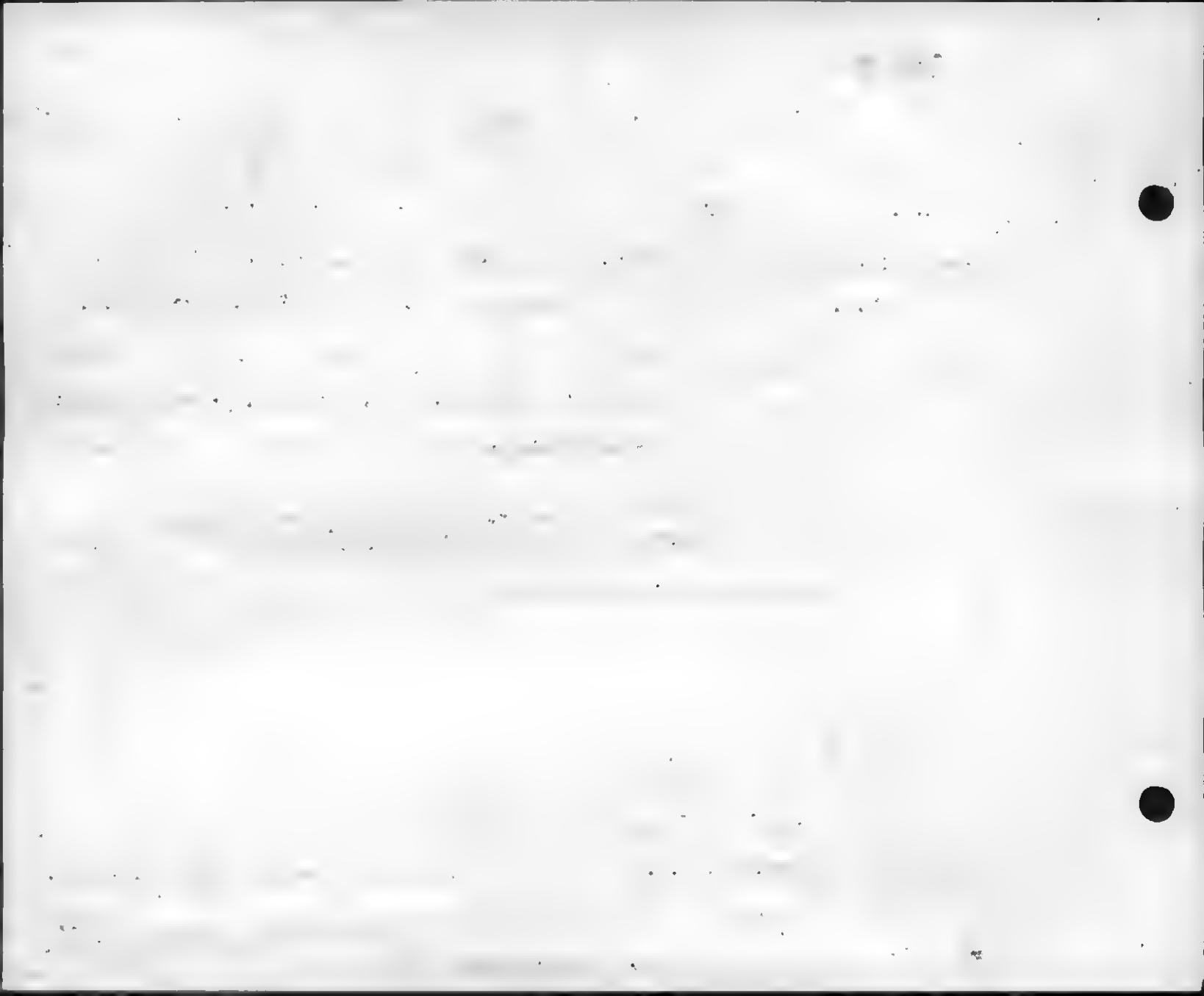
- 1 -

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I. DECEASED NAME (Type or print)		First Sarah	Middle E.	Last Bowe	2a. DATE OF DEATH Month 3 Day 28 Year 68	2b. HOUR 12:30	
3. SEX Female		4. RACE Negro		S. DATE OF BIRTH 11/08/09	6. AGE (in years last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0 IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Glenn Dale (rural)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laundry		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1424 R. Street, N.W.		
14. FATHER'S NAME First Henry		Middle Commander	Last Mary	15. MOTHER'S MAIDEN NAME First Mary		Middle Sylvester	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-20-1744		17. INFORMANT Mary L. Rowe, Daughter		Address Name as patient	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 41 day (b). DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease with (c) congestive heart failure & auricular fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town	County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 3/27 , 19 68 , to 3/28 , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 3/28 , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE Moe Weiss		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3/28/68		
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) 4/2/68		23b. DATE 4/2/68	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park	23d. LOCATION (City or Town) Landover	(County) MD.	(State)	
24. FUNERAL DIRECTOR R.N. Hartman Co. 1324 3rd St. N.W.		ADDRESS APR 2 - 1968	25a. RECD BY REGISTRAR 1003 S.D. REGISTRATION NUMBER Charles J. Gage				



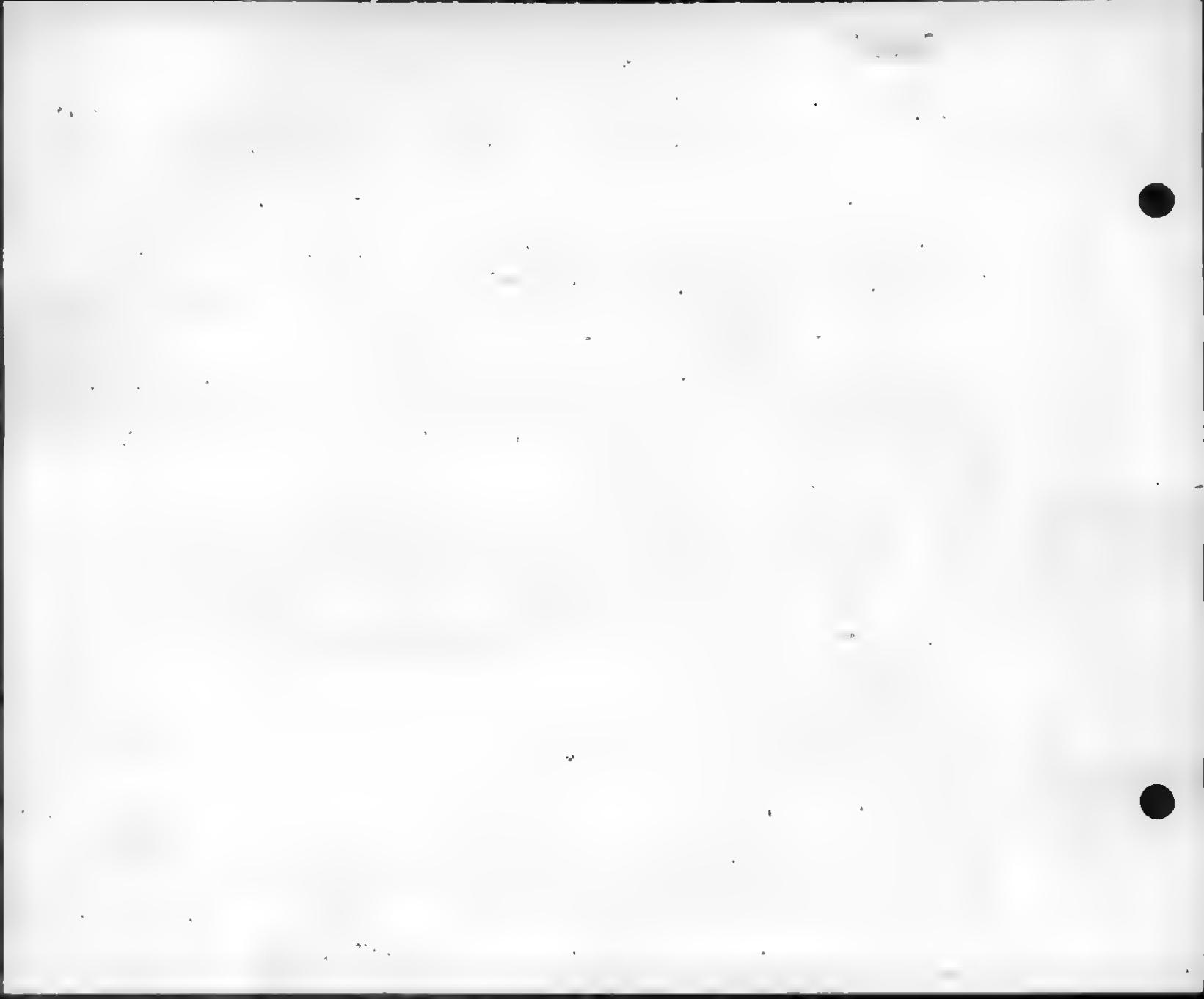
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

64523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Daisy	Middle A,	Last Boywell	2a. DATE OF DEATH March Month 4 Day 68 Year 12/45 A.M.	2b. HOUR 12/45 A.M.	
3 SEX female	4 RACE white	5. DATE OF BIRTH 5/12/85			6. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWNSHIP College Park Prince Georges Md.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4719 Edgewood Road	
14. FATHER'S NAME Charles		Middle Sanford	Last	15. MOTHER'S MAIDEN NAME Suellen	Middle	Last Rowe	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 579 12 3279			17. INFORMANT hospital records	Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>489X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause lost. (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>PARKINSON'S DISEASE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>2-19</u> , 19 <u>68</u> , to <u>3-4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>C.J. Houmann</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>4 MARCH 68</u>		
22d. PHYSICIAN'S NAME (Type) <u>C.J. HOUMANN M.D.</u>		22e. ADDRESS <u>RIVERDALE MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 6, 1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Ft Lincoln Cemetery</u>			23d. LOCATION (City or Town) <u>Colmar Manor Pro Geo Md.</u>	(County) (State)
24. FUNERAL DIRECTOR		ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 7 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

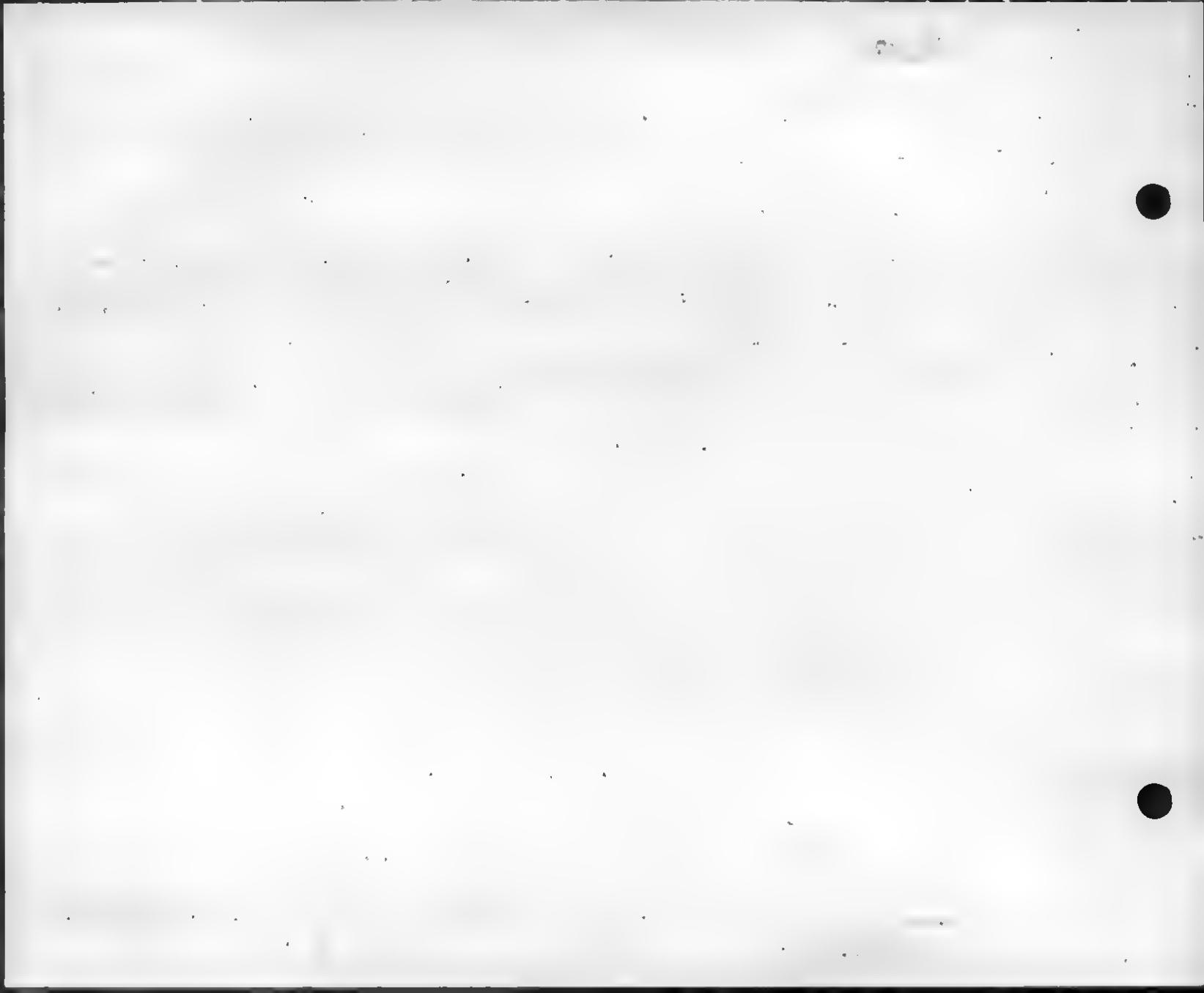
04580

0452

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Address 1 and 2 should be filed with the State Dept. of Health prior to burial cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First James	Middle L.	Last Brannan	2a. DATE OF DEATH Month March	Day 2	Year 1968	2b. HOUR 3:00 P.M.	
3. SEX male		4. RACE white		S. DATE OF BIRTH Sept 24, 1909	6 AGE (In years last birthday) 58		7. UNDER 1 YEAR MONTHS YRS.		
7a. BIRTHPLACE (State or foreign country) Washington D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Prince George's				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6312 Inwood St Cheverly Md			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Optical Ins. U.S. Government		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13c. CITY OR TOWN Prince George's		13d. INSIDE CITY, M.T.S? YES	13e. STREET AND NUMBER 6312 Inwood st		13f. CITY OR TOWN Cheverly, Md.		
14. FATHER'S NAME First Joseph C Brannan		Middle	Last	15. MOTHER'S MAIDEN NAME First Mary G. Tice		Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 579 07 6851		17. INFORMANT Margaret A Brannan		Address Cheverly, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> Due to, or as a consequence of <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Due to, or as a consequence of (c) </p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State		
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1962</u>, to <u>3-1-1968</u>, that (I) (we) last saw the deceased alive on <u>3-1-1968</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>John Kehoe</i>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-4-68			
22d. PHYSICIAN'S NAME (Type) John Kehoe MD		22e. ADDRESS Riverdale, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 6, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland Pro. George, Judge			
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE MAR 7 1968 REGISTRAR'S SIGNATURE <i>Judge</i>						



FOR STATE
HEALTH DEPT.

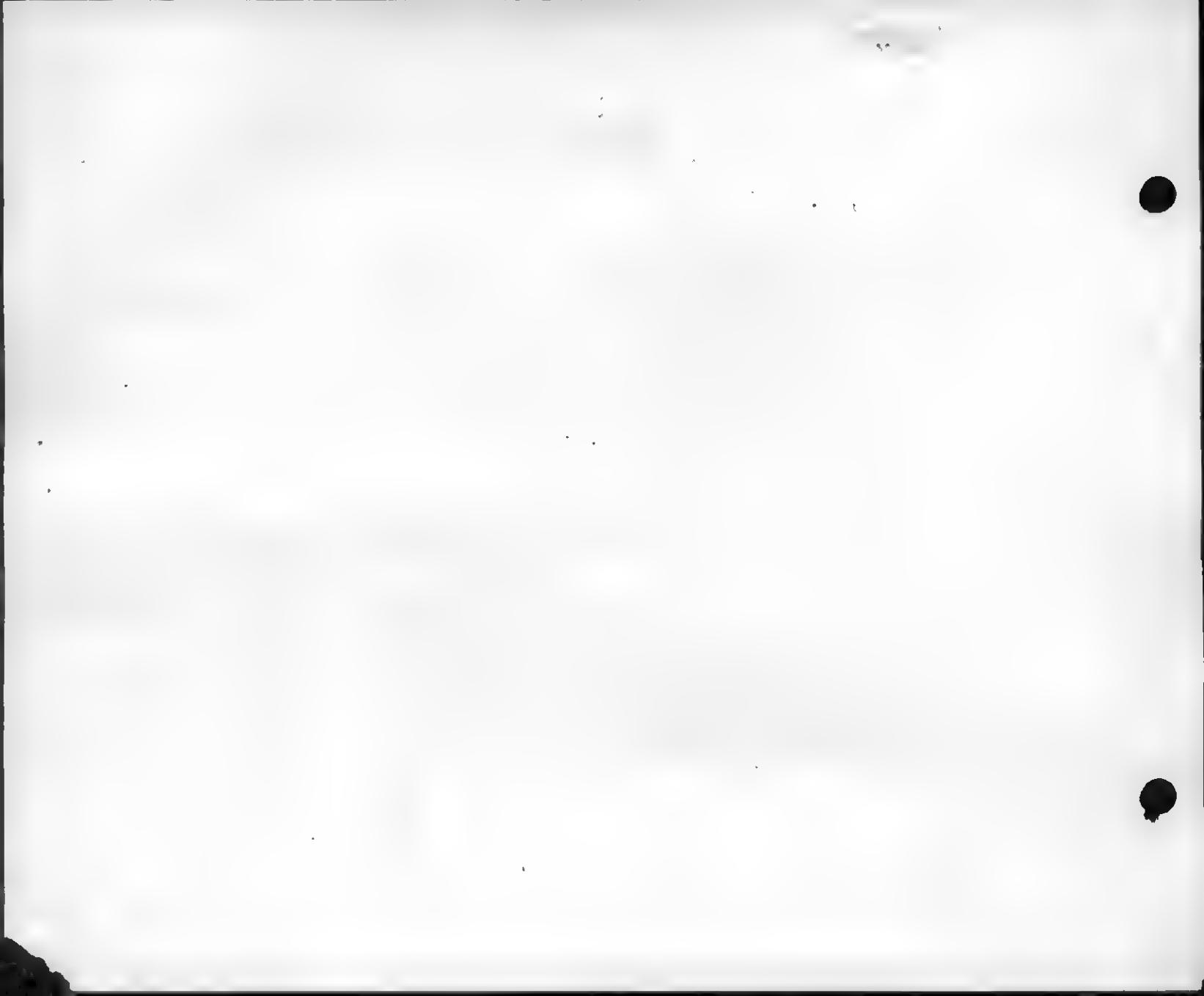
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR	
			Fannie	B	Branson	3-13-68			12:30pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years at birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. IF HRS HOURS	10. MIN	2c. DATE PRONONCED DEAD Month	Day	Year	2d HOUR
Female	Negro	28 Sept. 1908	59 yrs					3	13	68	1912:30pm
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Practical Nurse			Furnish		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission), STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
District of Columbia			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			302 16th. St., S.E.		
4. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John Proctor						Josephine Harley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Benjamin Branson			a. Same as 10		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease over 1 hr. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4-18											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d AUTOPSY?		
19c. DATE OF OPERATION			19d. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19e. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			2d AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Kehoe MD</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 3-14-68		
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3-16-68			23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial, Suitland, Md.			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Tollins, Inc.			ADDRESS 4339 Hunt Pl. N.E.			25a. REC'D BY REGISTRAR MAR 15 1968			25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>		



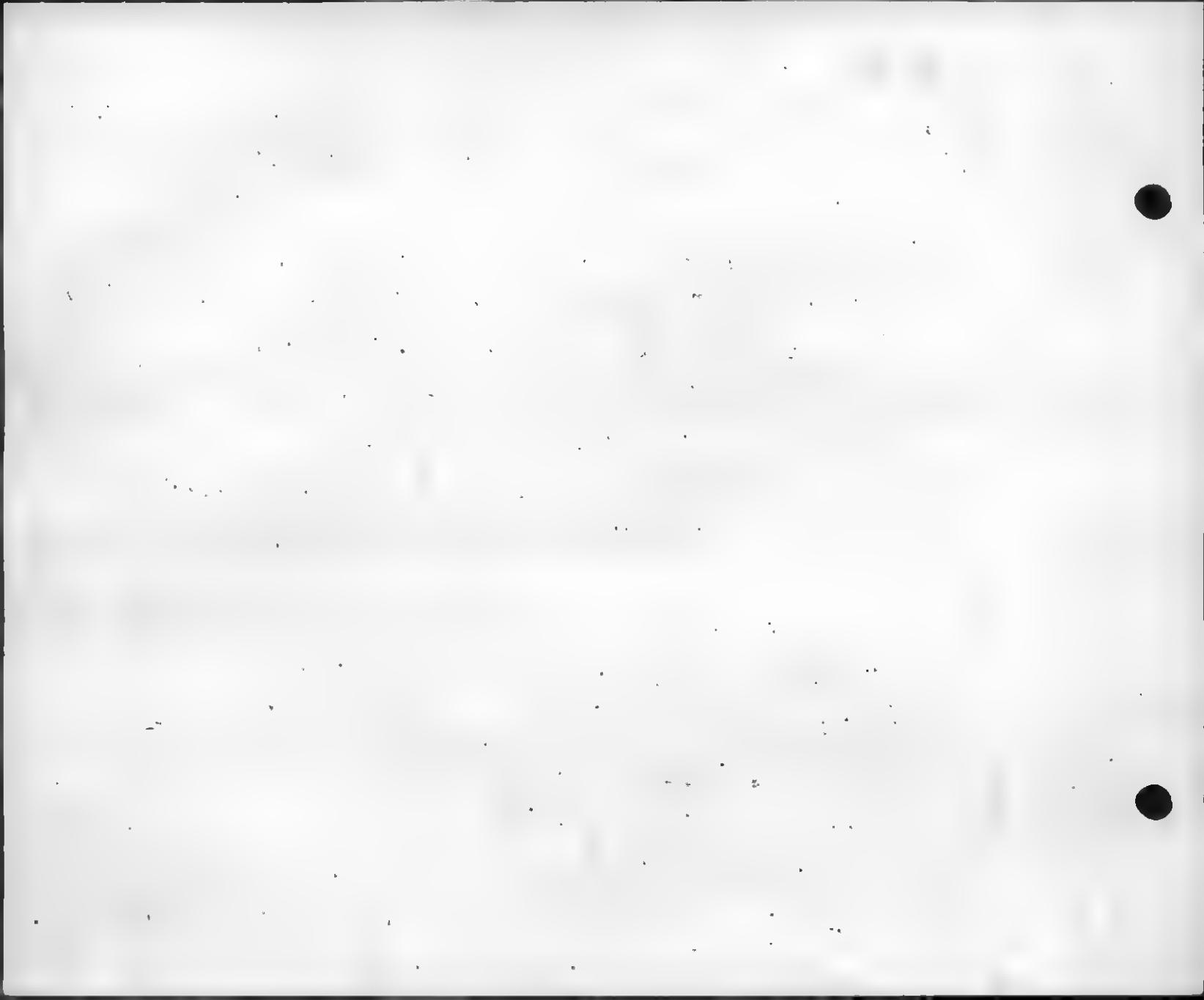
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Chester McMillian</i>	Middle <i></i>	Last <i>Bray</i>	2a DATE OF DEATH Month <i>MAR.</i>	Day <i>3</i>	Year <i>1968</i>	2b HOJR <i>5 PM</i>	
3. SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>12-2-1880</i>		6 AGE (in years last birthday) <i>80</i>	7. IF UNDER 1 YEAR MONTHS <i></i>	8. IF UNDER 24 HRS. DAYS <i></i>	9. IF HOURS HOURS <i></i>	10. MIN <i></i>	
7a BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH <i>Prince George</i>		Md		
10 CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pine View Gardens</i>		12a USUA. OCCUPAT OK (Kind of work done during most of working life, even if retired) <i>Engineer</i>		12b KIND OF BUSINESS OR IND.STRY			
13a JSUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Virginia</i>		13c. CITY OR TOWN <i>Arlington</i>		13d. INS'D CITY JAMES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>4409 North 17th St.</i>				
14. FATHER'S NAME First <i>Thomas</i>		Middle <i></i>	Last <i>Bray</i>	15. MOTHER'S MAIDEN NAME First <i>Ella J. McMillian</i>		Middle <i></i>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Unknown</i>		16b. SOCIAL SECURITY NO <i>379-03-5668-A-B Margaret Brimes LPN</i>		17. INFORMANT <i>Lot 15 RED Box 434 Upper Marlboro MD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>501 AM</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPIRATORY ARREST							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>		(b) TERMINAL BRONCHOPNEUMONIA 12 HRS.							
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED CARCINOMATOSIS - BRONCHOGENIC CA 5 1/2 MOS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>NONE</i>									
19a. DATE OF OPERATION <i>Oct '67</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>BRONCHOGENIC CA</i>		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>None</i>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, name medical practitioner) <i></i>		21b. TIME OF INJURY Hour AM Month Day Year <i>None</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>None</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not working <input checked="" type="checkbox"/> At work <i>None</i>		21e. PLACE OF INJURY At home Farm Street, Factory Office Building, etc. <i>None</i>		21f. LOCATION Street or R.F.D. No <i>None</i>	City or Town <i>None</i>	County <i>None</i>	State <i>None</i>		
22a. I certify that (1) this hospital attended the deceased from <i>Dec 30, 1967</i> , to <i>Present</i> , that (1) (we) last saw the deceased alive on <i>March 2 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Arthur Shaver Jr MD</i>		ATTENDING DEGREE <i>MD</i>		<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <i>3/3/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>ARTHUR SHAVER JR</i>		22e. ADDRESS <i>8808 BRANCH AVE, CLINTON, MD</i>							
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/6/68</i>		23c. NAME OF CEMETERY OR CREMATORIY <i>National Memorial Pk.</i>		23d. LOCATION (City or Town) <i>Falls Church Fairfax Va.</i>		(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>Arlington Funeral Home</i>		ADDRESS <i>Arlington, VA</i>		25a. REC'D. BY REGISTRAR <i>Charles J. Jagger</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jagger</i>			
30M REV 1/68		30M REV 1/68		30M REV 1/68		30M REV 1/68			

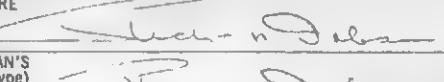


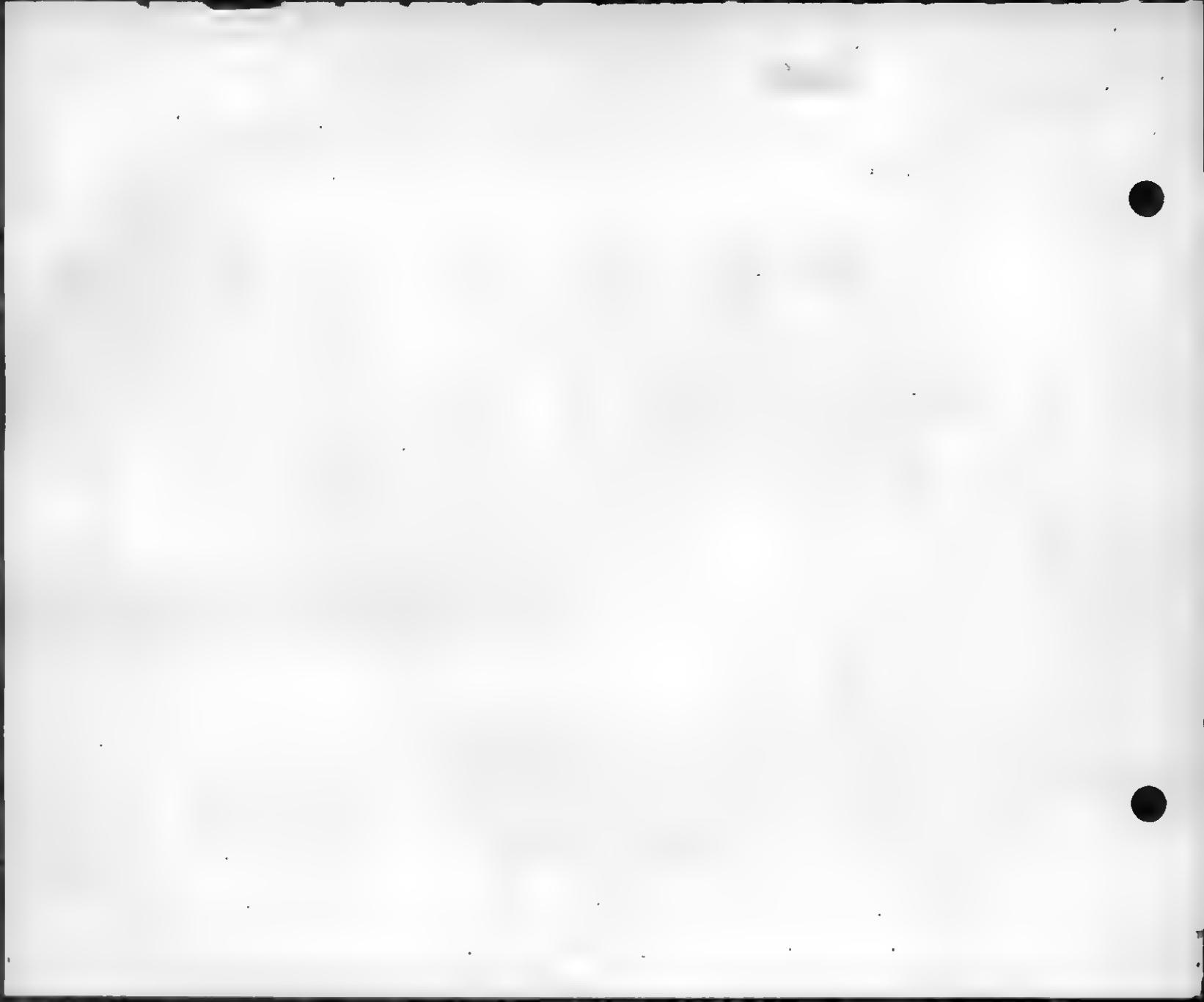
HOSPITAL OR NURSING HOME: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEO.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BADEN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BADEN				
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS RT 1 BOX 361				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle HYDE	Last BRAY			
4. DATE OF DEATH	Month MARCH	Day 23	Year 1968			
5. SEX FEMALE	6. COLOR OR RACE CAV.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1913			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IBM OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY COURT HOUSE	11. BIRTHPLACE (County & State, or foreign country) P.G. MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME NORVAL P. HYDE	14. MOTHER'S MAIDEN NAME RHODA C. HYDE	Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 579-20-8089	17. INFORMANT GARY A. BRAY, BADEN, MD.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Nursing Carelessness Co of ovary				
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		1 year				
DUE TO (c)		1 yr				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) BADEN	(County) MD.	(State) MD.
21. I certify that (I) (this hospital) attended the deceased from 1-16 , 1957, to 3-23 , 1968, that (I) (we) last saw the deceased alive on 7-23 1968 and that death occurred at 8:00 AM , from the causes and on the date stated above.						
22a. SIGNATURE 		22b. DATE SIGNED 3-23-68				
22c. PHYSICIAN'S NAME (Type) Richard Dobson, M.D.		22d. ADDRESS 101 Brandywine, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-26-68	23c. NAME OF CEMETERY OR CREMATORIAL ST PAULS	23d. LOCATION (City, town or county) (State) BADEN, MD.		
24. FUNERAL DIRECTOR		ADDRESS Hunter Funeral Home, WALDORF, MD.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

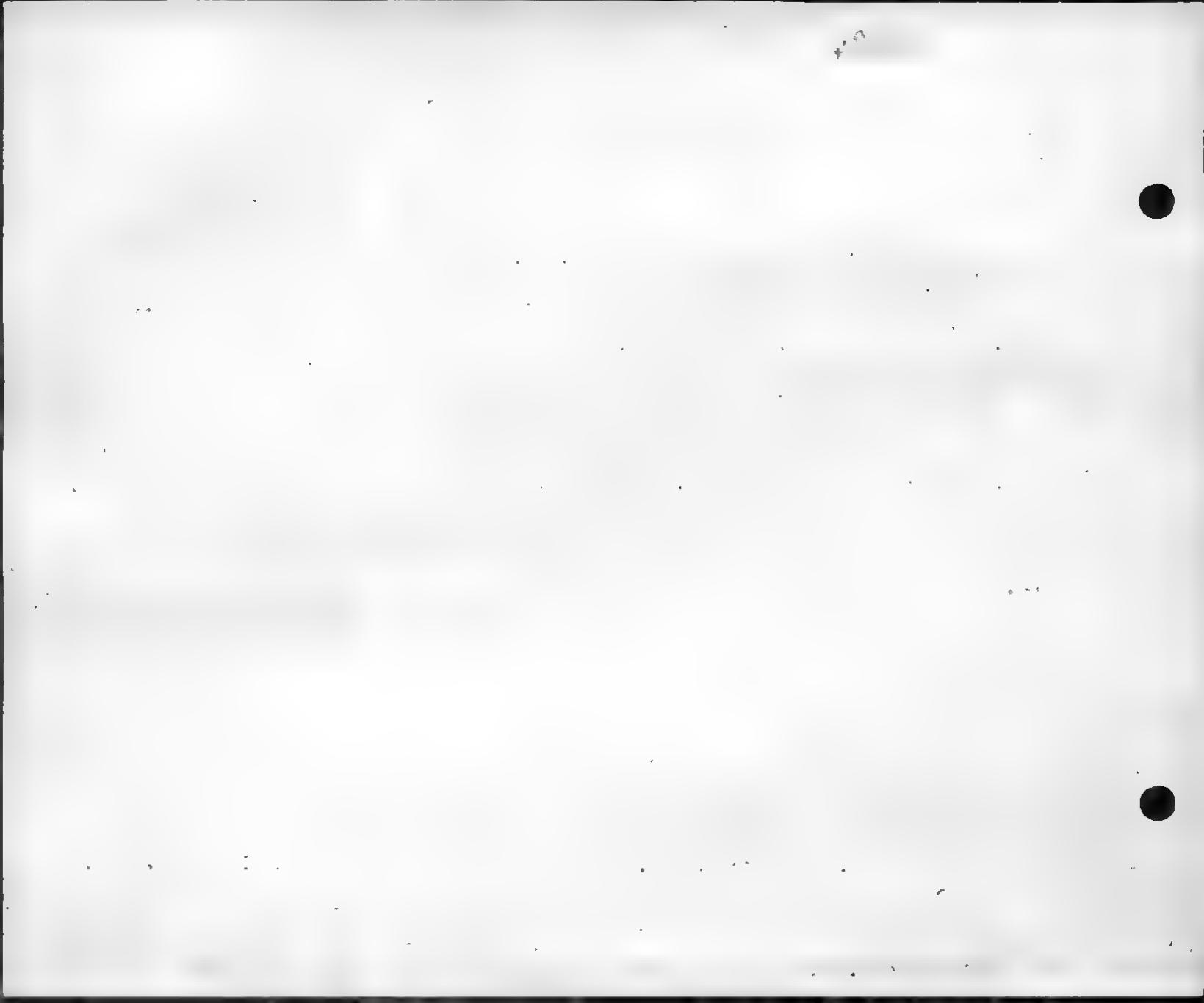
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1
M

04534

J 4526

1. DECEASED NAME (Type or print)		First Ethel	Middle	Last Briggs	2a. DATE OF DEATH 3 Month 25 Day 68 Year	2b. HOUR 1:00 PM
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 8-8-11		6. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George		
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Brentwood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4509 Banner St.		
14. FATHER'S NAME Howard	First Middle Graham	Last	15. MOTHER'S MAIDEN NAME First Sarah Wallace	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. —	17. INFORMANT Medical Records	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 16-41 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Bronchogenic CA Right lung (c) DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 4 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 15-8						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-14, 19 66, to 3-25-68, 19 , that (I) (we) last saw the deceased alive on 2-14-68 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE C. J. Houmann		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-25-68		
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.		22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md.				
23a. CURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-30-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Queens Chapel	23d. LOCATION (City or Town) Norkirk Rd	(County) Charles Co.	(State) Md.	
24. FUNERAL DIRECTOR H.J. Washington	ADDRESS 4925 Decatur	25a. REC'D BY REGISTRAR APR 2 - 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm, 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 2a, 2c, 2d, 2f, 2g, 2h, 2j, 2k, 2l, 2m, 2n, 2o, 2p, 2q, 2r, 2s, 2t, 2u, 2v, 2w, 2x, 2y, 2z

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR
William Brown					Brown	March	24	1968	10 AM	10 AM	68	130 AM
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years at death) MOS. DYS. YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 MRS. HOURS	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR
M	C	May 17 1917	80			March	24	1968	10 AM	68	130 AM	
7a. BIRTHPLACE (State or foreign Country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		Prince Georges				
South Carolina		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince Georges		Clay				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (not a hospital give street address)			12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverley			Prince George's General Hospital			Laborer			Clay			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13c. C.TY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
DC			Wash			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1407 Grindall NE			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Thomas Brown						Adessa Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
(If yes give war or dates of service)						Adessa Brown			Wash			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) Surgical Shock												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause												
(b) Wounds multiple & Severe												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. AUTOPSY?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJRY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
						RFD 495 Laurel Md						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			Dayton Watkins			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)			DAYTON J. WATKINS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) (County) (State)			
Burial			3-29-68			Lincoln Memorial			Suitland Maryland			
24. FUNERAL DIRECTOR			Funeral Home			ADDRESS			25a. REC'D BY REGISTRAR			
John T. Rhines Co.			3015 12th St., N.E.			Wash. D.C.			25b. REGISTRAR'S SIGNATURE			
									John T. Rhines Co.			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

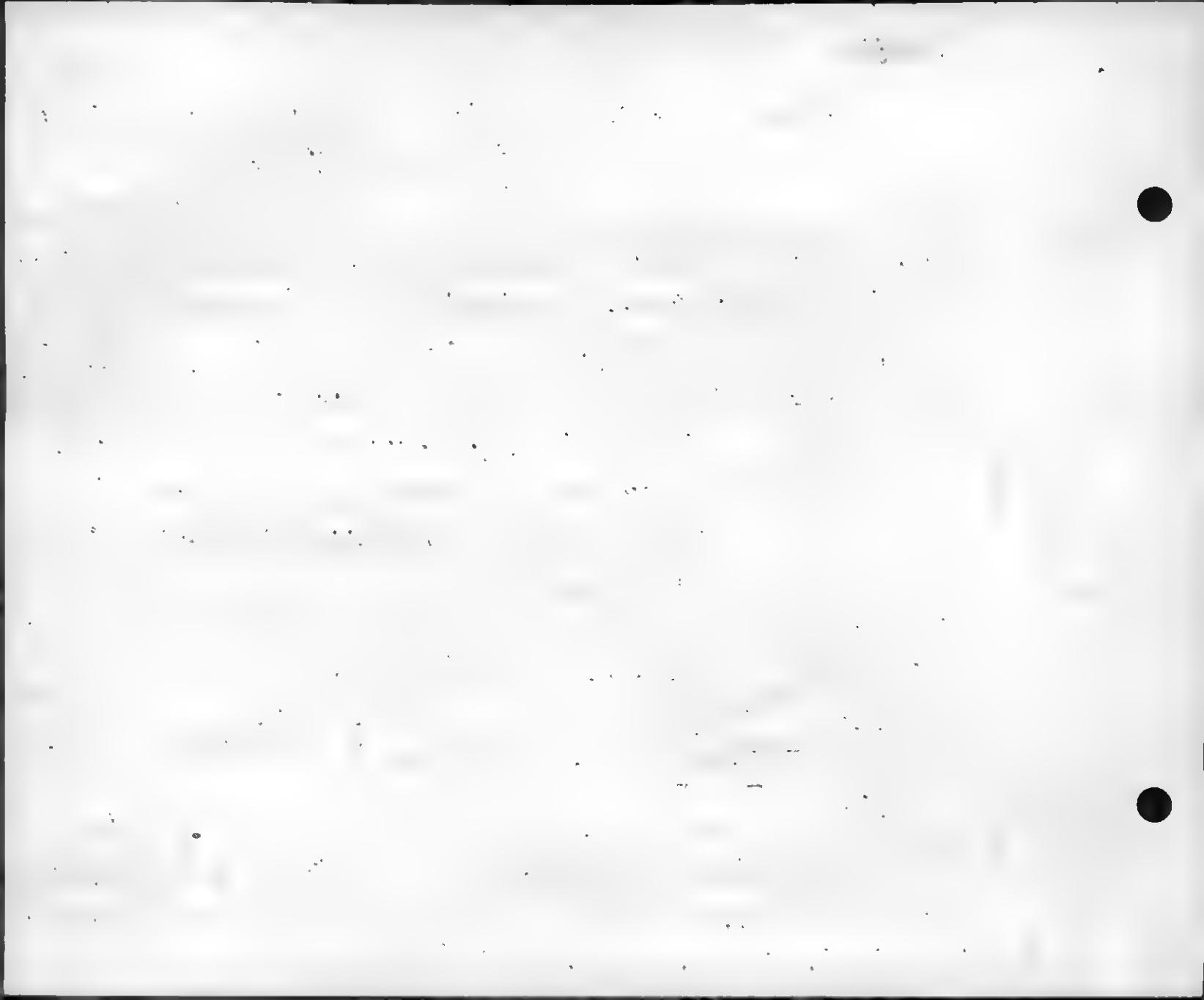
CERTIFICATE OF DEATH

05035

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

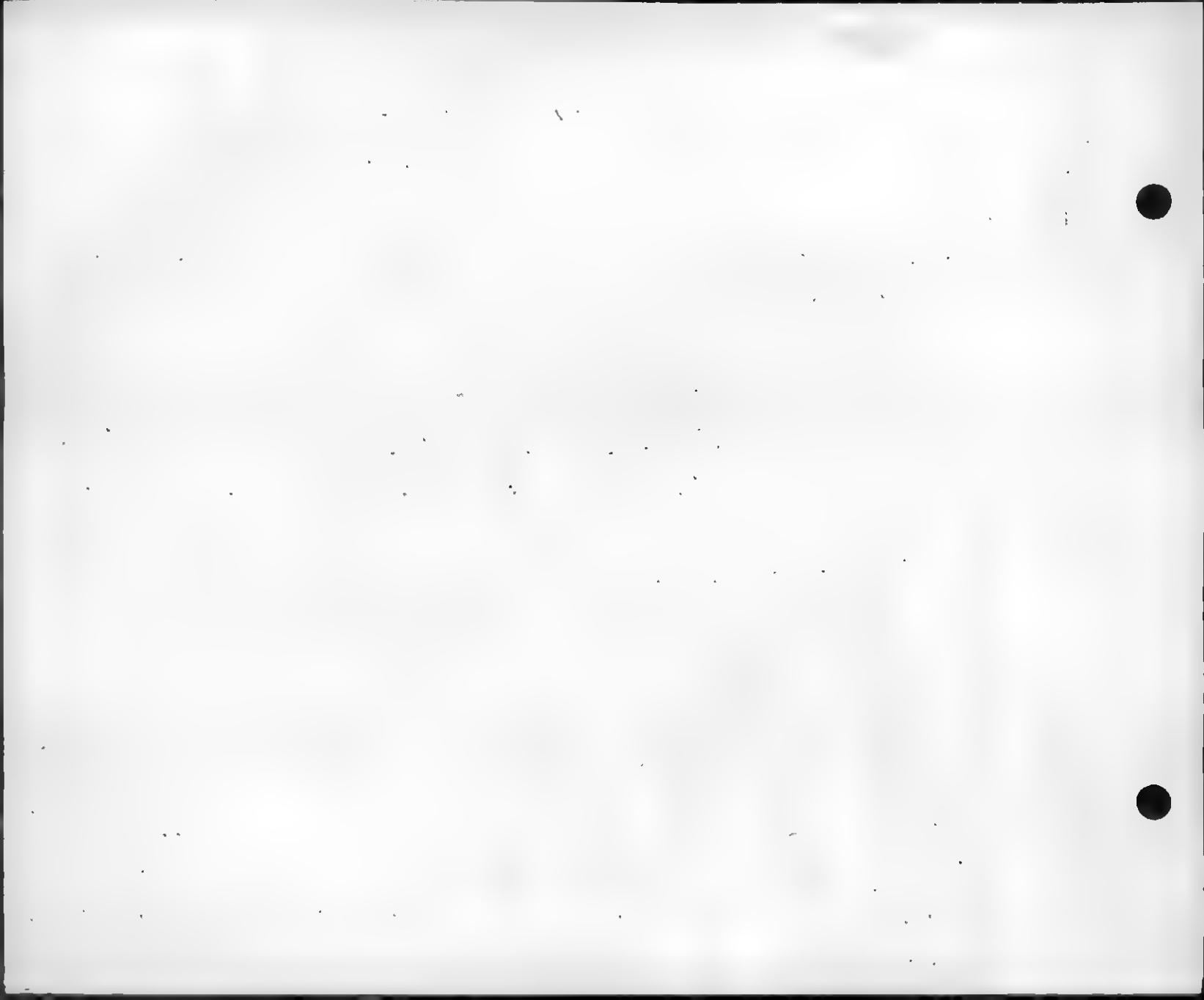
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 150 PM	
3 SEX		4. RACE		S. DATE OF BIRTH	6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CTY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER		
14. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First		Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
YES 1916-1918				MABEL BUCK (WIFE)		7813 CIRCLE DR., PR. GEO. DR. CLINTON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>CEREBROVASCULAR ACCIDENT, ACUTE 12 HRS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDI-VAS. DISEASE 13 YRS</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Noce</u>									
19a. DATE OF OPERATION <u>Noce</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Noce</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR COMORBIDITY <input type="checkbox"/> LIFE OF DEATH (If either, fully describe condition)		21b. TIME OF INJURY HOUR A.M. Month Year <u>Noce</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Noce</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> While <input type="checkbox"/> At work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) <u>Noce</u>		21f. LOCATION Street or R.F.D. No. <u>Noce</u>		City or Town	County	State	
22a. I certify that (I) (his hospital) attended the deceased from <u>SEPT</u> , 19 <u>59</u> , to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>MAR 24 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arthur Shaver Jr</u>		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>3/24/68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)
Burial		March 27, 68		Fort Lincoln Cemetery - Bladensburg		Maryland			
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		ADDRESS		Wash. DC		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Mar 26 1968</u>		
30M REV. 1-68									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician, or it may be detached for use as the burial-transit permit. Then please remove carbon paper from page 3, which will then be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b. HOUR 9:59 P.M.
SISTER Anne FRANCIS Byrne					3	20	1968	
3 SEX FEMALE		4 RACE White		S DATE OF BIRTH Dec 13, 1891	6 AGE (In years last birthday) 76 yrs		F JNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Bronx, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince Georges Md			
10 CITY OR TOWN OF DEATH Hyattsville, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Marine		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Religious Non Religious		12b KIND OF BUSINESS OR INDUSTRY RELIGIOUS		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b. CITY OR TOWN MONTGOMERY		13c CITY OR TOWN BETHESDA	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4001 000	Georgetown, Road.	
14. FATHER'S NAME First JAMES		Middle J.	Last BRESLIN	15. MOTHER'S MAIDEN NAME First Alice	Middle	Last TOOMEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no) or unknown		16b SOCIAL SECURITY NO. 220-58-5229		17 INFORMANT Sister M. Dolores		Address 4922 LASALLE Rd. HYATTSVILLE, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mos.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 352X		DUE TO, OR AS A CONSEQUENCE OF Basilar Artery Thrombosis						
(b)		DUE TO, OR AS A CONSEQUENCE OF Cerebral Arteriosclerosis				10 yrs.		
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diseases mellitus								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from July , 1967, to 20 March 1968 , that (I) (we) last saw the deceased alive on 20 March 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Joseph J. Wallace, M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 20 March 1968			
22d. PHYSICIAN'S NAME (Type) JOSEPH J. WALLACE M.D.		22e. ADDRESS 1830 K ST N.W. WASH. 6, D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-22-68		23c. NAME OF CEMETERY OR CREMATORIAL Visitation Convent Cemetery		23d. LOCATION (City or Town) BETHESDA MONTGOMERY, MD.	(County)	(State)
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 3821 14th St N.W. Wash.		25a. REC'D BY REGISTRAR DAT MAR 26 1968		25b. REGISTRAR'S SIGNATURE James J. Collins		

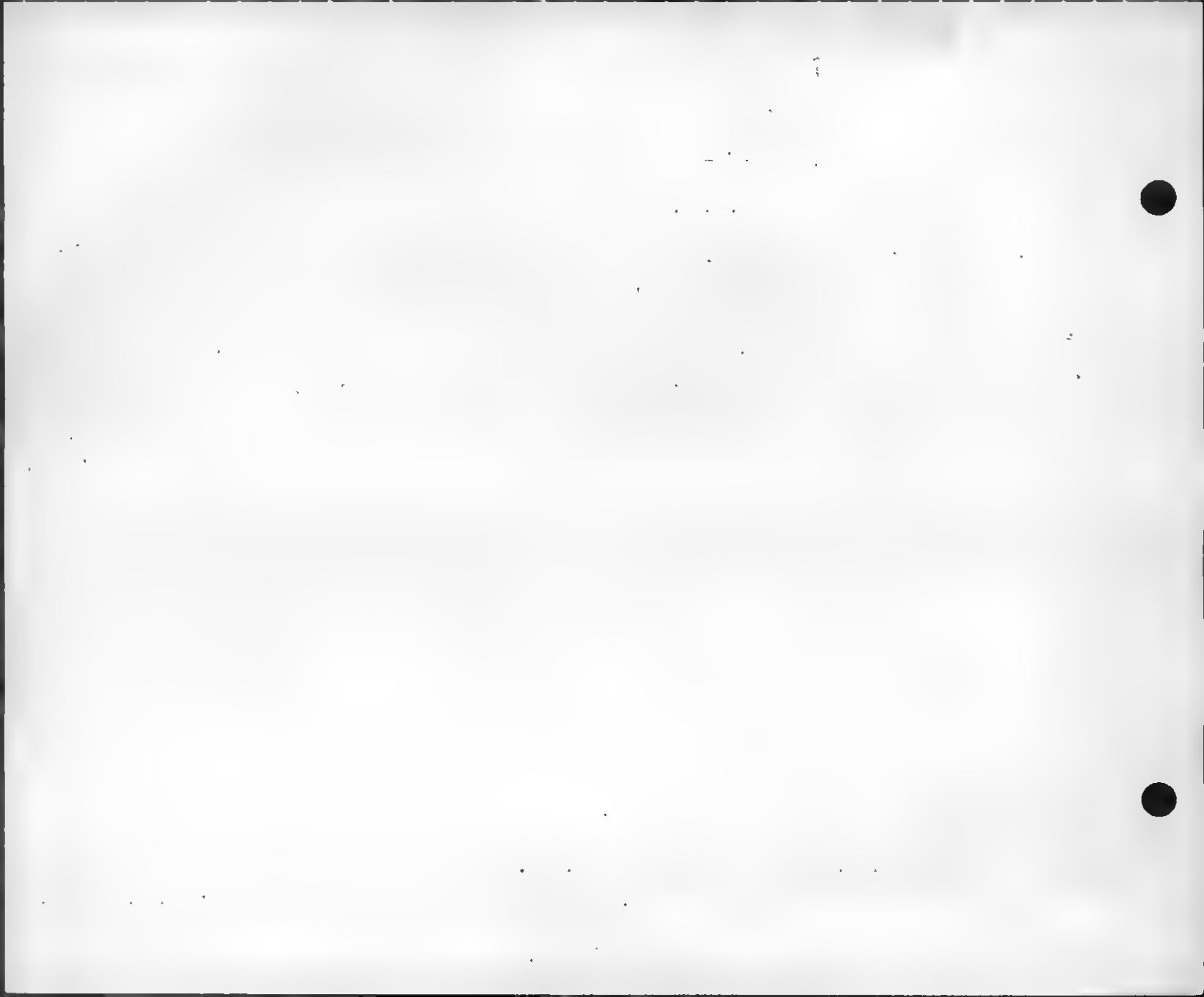


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the body or remains. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	
			Charles	Arthur	Caldwell	<input type="checkbox"/> 3-17-68			19	1	10pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS			2b. HOUR			
Male	White	10-26-1911	56 YRS.	MONTHS	DAYS	HOURS	MIN					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD Month Day Year		
Texas		U.S.A.		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Prince George's		2d. HOUR		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during day, if applicable, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital					Radio Engineer			Government	
13a. JSLAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland			13c. CITY OR TOWN		13d. INSIDE CITY, MTS?			13e. STREET AND NUMBER				
			Prince George's		Cheverly			YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	6007 Kilmer Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Alvin			B.	Caldwell		Clara			J.	Jessie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS				
no			380 01 8796		Maryse Caldwell Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) Heart failure												
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) minutes												
DUE TO, OR AS A CONSEQUENCE OF (c) over 2 yrs.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
4-200			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
									YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John Kehoe</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 3-18-68			
23a. BURIAL CREMATION BURIAL			23b. DATE 3/18/68			23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln			23d. LOCATION (City or Town) Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR MAR 20 1968			25b. REGISTRAR'S SIGNATURE <i>Charles J. Gasch</i>			
Francis Gasch's Sons Hyattsville, Md.												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1
M
3536

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Baby	Middle Girl	Last "B" CARR	2a. DATE OF DEATH Month Day Year March 9, 1968	2b. HOUR 12:05 PM		
3. SEX Female	4 RACE Caucasian	5. DATE OF BIRTH March 9, 1968			6. AGE (In years last birthday) YRS. -	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH Prince Georges			Md.		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen'l Hospital			12a. USJA: OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5302 Hamilton Street				
14. FATHER'S NAME William Marvin Carr	First Middle Last	15. MOTHER'S MAIDEN NAME Mary Jane Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO	17. INFORMANT Mother				Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>March 9, 1968</u> , to <u>March 9, 1968</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>March 9, 1968</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death								
22b. SIGNATURE <i>Joseph A. Murgalo, M.D.</i>	22c. DATE SIGNED March 13, 1968							
22d. PHYSICIAN'S NAME (Type) Joseph A. Murgalo, M.D.	22e. ADDRESS Prince George's General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/23/68	23b. DATE 3/23/68	23c. NAME OF CEMETERY OR CREMATORIAL Prince George's Gen. Hosp.	23d. LOCATION (City or Town) Cheverly, Maryland	(County)		(State)		
24. FUNERAL DIRECTOR DALE W. PARKER, JR., ADMINISTRATOR	ADDRESS 1311 W. PRESTON ST., BALTIMORE, MD 21201	25a. REC'D BY REGISTRAR N 27 1968	25b. REG STRG'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

34535

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Baby	Middle Boy "C"	Last CARR	2a DATE OF DEATH Month March	Day 9, 1968	12b. HOUR 7:10 PM	
3. SEX Male		4. RACE Caucasian		S. DATE OF BIRTH March 9, 1968	6. AGE (in years last birthday) -		IF UNDER 1 YEAR MONTHS 5	F. UNDER 24 HRS. DAYS 22
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5302 Hamilton Street			
14. FATHER'S NAME First William Marvin Carr		Middle	Last	15. MOTHER'S MAIDEN NAME First Mary Jane Brown		Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mother		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9, 1968, to March 9, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 9, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE <i>Joseph A. Murgalo, M.D.</i>				22c. DATE SIGNED March 13, 1968				
22d. PHYSICIAN'S NAME (Type) Joseph A. Murgalo, M. D.		22e. ADDRESS Prince Georges General Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/23/68	23c. NAME OF CEMETERY OR CREMATORIY Prince Geo. Gen. Hospital	23d. LOCATION (City or Town) Cheverly, Maryland		(County) (State)		
24. FUNERAL DIRECTOR <i>CHARLES J. PENN, JR., ADMINISTRATOR</i>		ADDRESS		25a. RECD BY REGISTRAR DATE MAR 27 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

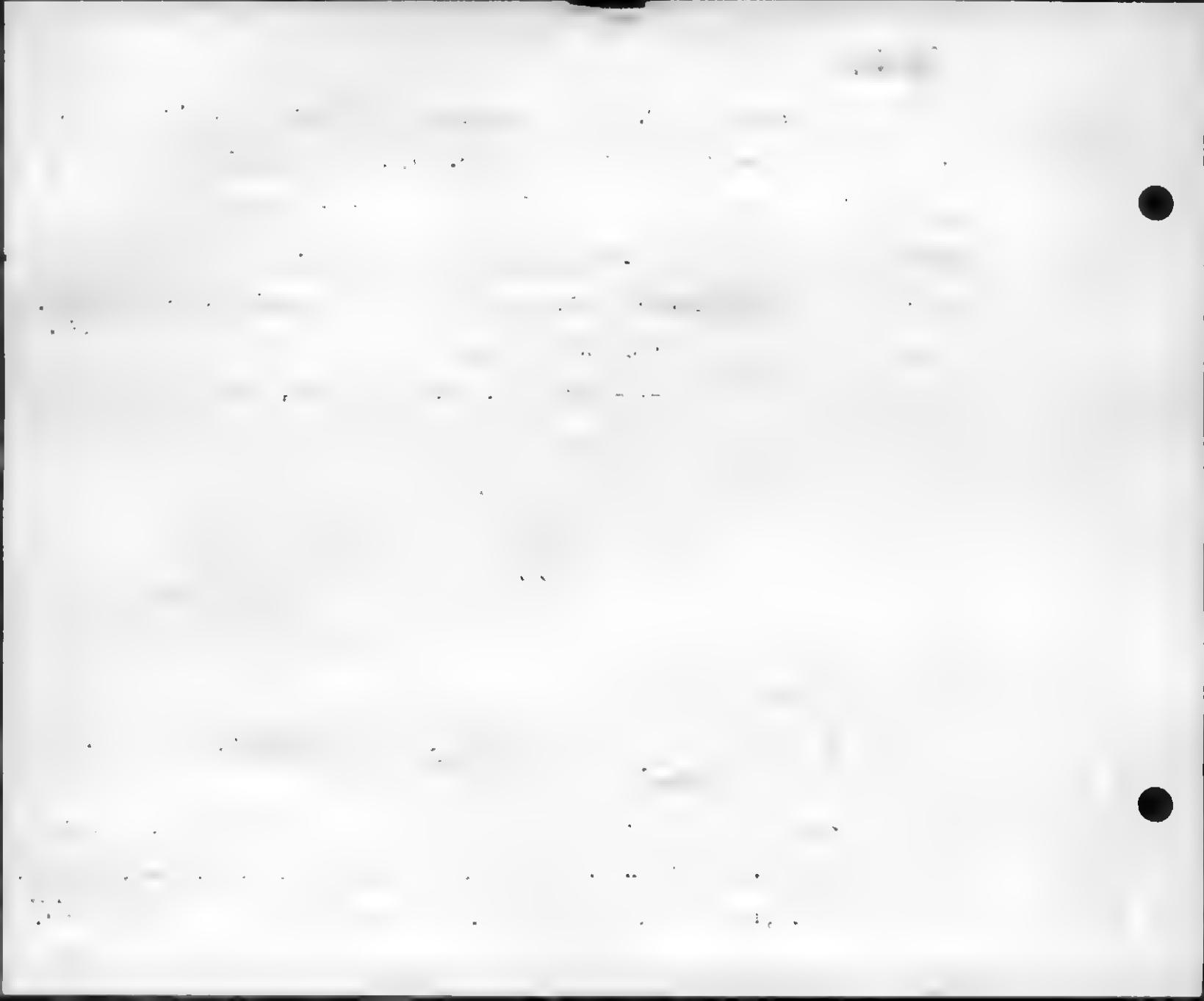


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Ralph	Middle S.	Lost Catterton	2a. DATE OF DEATH Month March	Day 6,	Year 1968	2b. HOUR P 2:30 M									
3. SEX		4. RACE Male	5. DATE OF BIRTH Aug. 25, 1918		6. AGE (In years last birthday) 55 56 yrs.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN								
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges											
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Attendant		12b. KIND OF BUSINESS OR INDUSTRY Service Station											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b. CITY OR TOWN Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER c/o Harold Cox: Pindell Rd.											
14. FATHER'S NAME First James		Middle Catterton	Lost	15. MOTHER'S MAIDEN NAME First Rosie		Middle Chaney	Address Mrs. Ruth Catterton, Bristol, Maryland										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. 218-12-9646		17. INFORMANT 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Encephalopathy , DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertension - Vascular , DUE TO, OR AS A CONSEQUENCE OF (c) 																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State													
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from March 2, 1968 , to March 6, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 6, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.										22c. DATE SIGNED March 7, 1968							
22b. SIGNATURE <i>Edwin J. Jensen, M.D.</i>		22c. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>															
22d. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M. D.		22e. ADDRESS Prince Georges General Hospital, Cheverly															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 9, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Harmony Chr. Cemetery		23d. LOCATION (City or Town) (County) (State) Owings Calvert Md.											
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>		ADDRESS Owings, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles J. Hutchins</i>											
30M REV. 1-68		DATE MAR 11 1968															

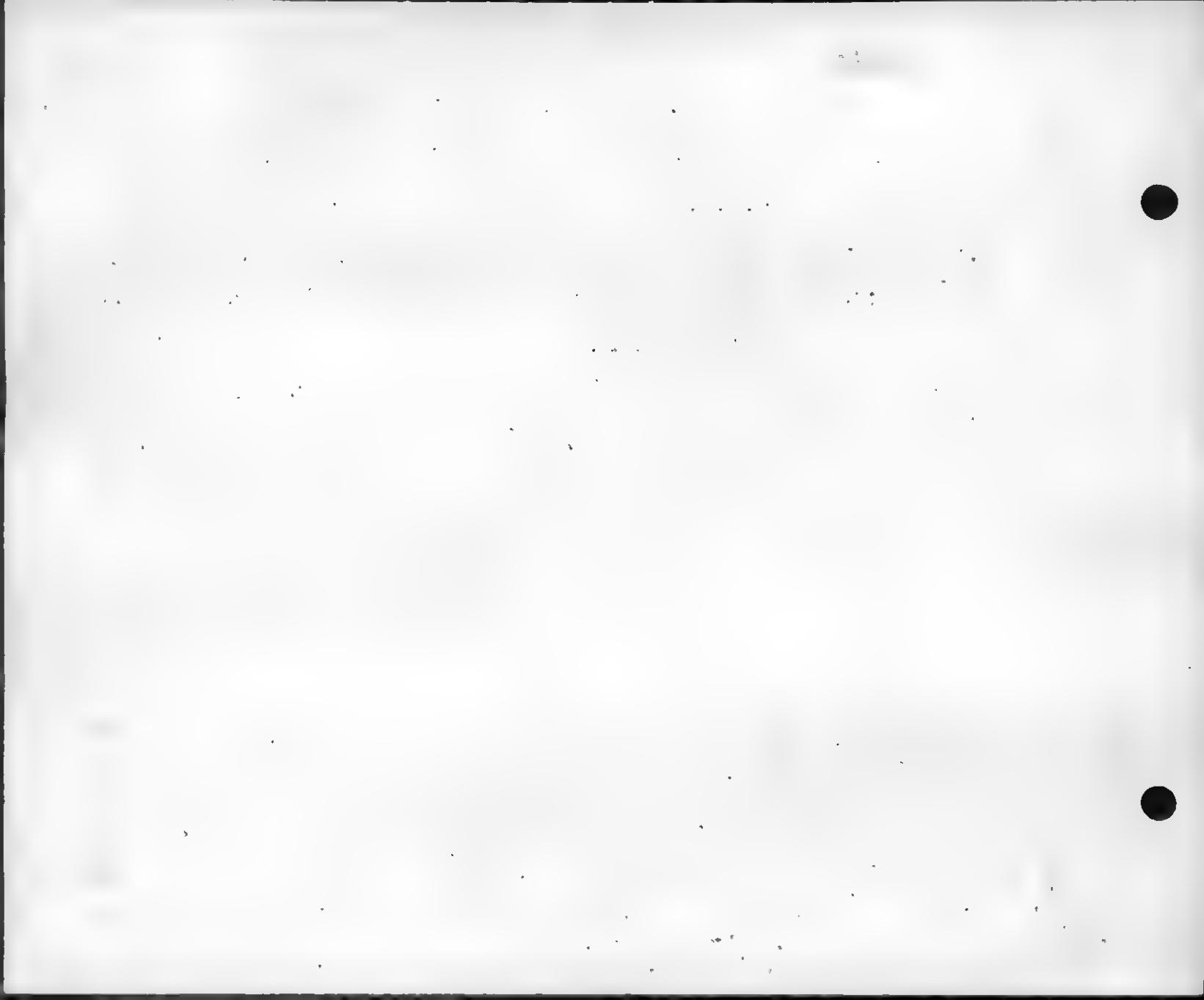


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First JAMES	Middle EDWARD	Last CAULFIELD	2d. DATE OF DEATH Month MAR	Day 4	Year 68	2b. HOUR A 6 : 45M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 12 JUN 1928		6. AGE (in years at death) 72 39 yrs.		IF UNDER 1 YEAR MONTHS 0		F. UNDER 24 HRS HOURS 0	
7a. BIRTHPLACE (State or foreign country) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S					
10. CITY OR TOWN OF DEATH ANDREWS AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFH			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) RETIREE AF OFF.			12b. KIND OF BUSINESS OR INDUSTRY MILITARY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY, L.M. TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3004 TWISTING LANE					
14. FATHER'S NAME First JAMES			Middle EDWARD	Last CAULFIELD	15. MOTHER'S MAIDEN NAME First HELEN		Middle MURPHY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO 722 14 7580		17. INFORMANT WIFE		Address SAME AS ITEM #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HODGKIN'S DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) storing the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YRS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 18 Feb 1968 to 4 Mar 1968 , that (I) (we) last saw the deceased alive on 1 Mar 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Allen D. Ward</i>		DEGREE ATTENDING PHYS.		22c. MED. DIRECTOR STAFF PHYS.		DATE SIGNED 4 Mar 1968					
22d. PHYSICIAN'S NAME (Type) ALLEN D. WARD, CAPT USAF		22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS									
23a. BURIAL, CREMATION, BURIAL REMOVAL (Specify)		23b. DATE 3/6/68		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery Arlington, Virginia		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland						25a. REC'D BY REGISTRAR MAR		25b. REGISTRAR'S SIGNATURE <i>Charles J. Rogers</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

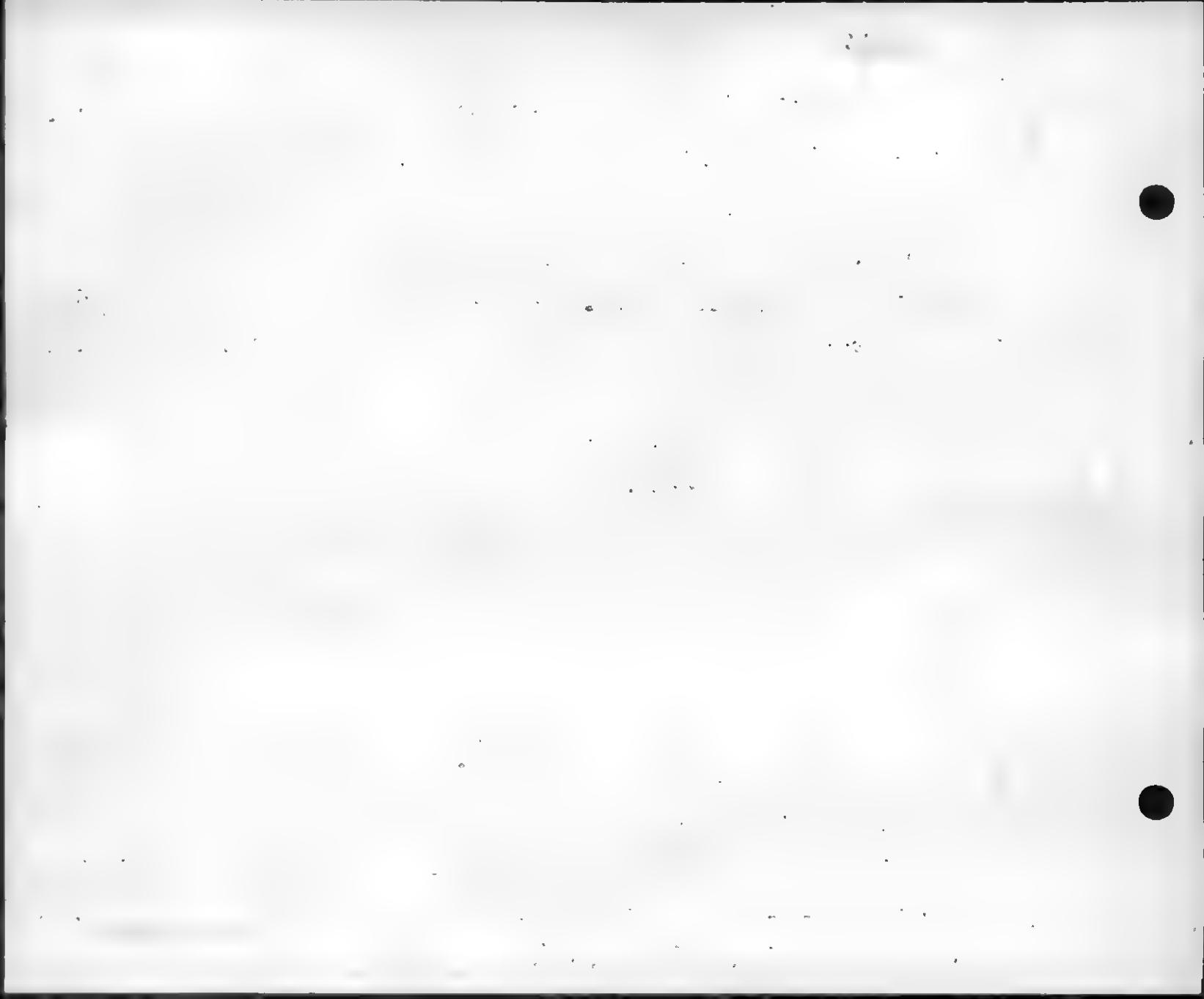


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician. Within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First VICTORIA	Middle ANN	Last CHAGNON	2a. DATE OF DEATH Month MARCH	Day 26	Year 68	26. HOUR A 1225 M
3 SEX Female	4. RACE Cauc.	5. DATE OF BIRTH 23 Mar 68			6. AGE (In years last birthday) YRS 2	IF UNDER 1 YEAR MONTHS 2	IF UNDER 24 HRS. HOURS 00 MIN 00	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges			
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Princess Anne		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Reside before admission) STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Oxon Hill	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 3025 Brinkley Road			
14. FATHER'S NAME First Albert		Middle George	Last Chagnon	15. MOTHER'S MAIDEN NAME First Ann	Middle Marie	Last Yonkin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Father	Address same as item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 23 Mar 68 , to 26 Mar 68 , that (I) (we) last saw the deceased alive on 26 Mar 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>William E. Palma, Capt USAF MC</i>		22c. DATE SIGNED 26 Mar 68		MD ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) WILLIAM E. PALMA CAPT USAF MC		22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS						
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 3-28-68	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) Arlington,		(County) Va.	(State)
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road SE, Washington, D.C.		ADDRESS 4308 Suitland Road SE, Washington, D.C.		25a. REC'D BY REGISTRY APR 1 1968	25b. REC'D BY AGENT John J. Jones			

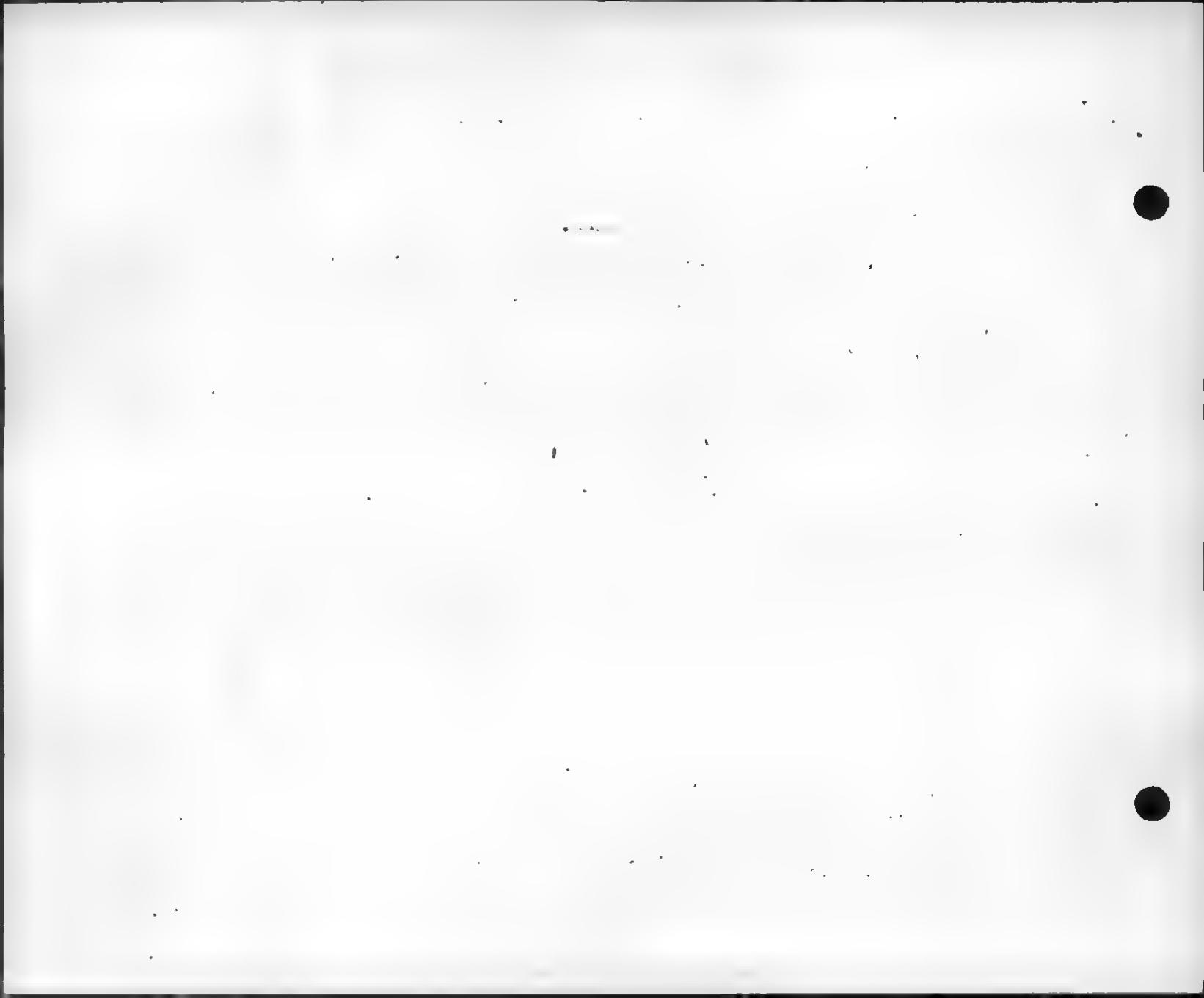


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, ~~page 3~~, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 21a&22a Film 398 MARYLAND STATE DEPARTMENT OF HEALTH
3/1/68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film G398 3/18/68 kk CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First	2. SEX	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Emma	E.	Female	Can.	Chaplin	Mar 9, 1968	4:30 P.M.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	S. DATE OF BIRTH 12-23-1871	9. COUNTY OF DEATH Pr. George	6. AGE (In years last birthday) 54 yrs.	1f UNDER 24 HRS MONTHS DAYS HOURS MIN
Brooklyn, N.Y.	U.S.A.	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY			
Clinton, Md.	Clinton Community	Receptionist	Medical			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.	CHARLES	La Plata	800 WASHINGTON AVE			
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last	
Thomas Coyne			Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) No	17. INFORMANT Kenneth Chaplin-La Plata, Md. 20646	Address			
	064-05-4132					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) BURNS and degree 60% Body surface DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> , 19 <u>68</u> , to <u>3-9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Robert W. Merkle</i>		DEGREE ATTENDING PHYS.	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>3-9-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>CLINTON, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5-12-68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>SACRED HEART</u>	23d. LOCATION (City or Town) <u>LA PLATA, CHARLES, MD.</u>	(County) (State)	
24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WALDORF, MD.</u>		ADDRESS	25a. RECD BY REGISTRAR <u>MAR 14 1968</u>	25b. REGISTRAR'S SIGNATURE <u>R. W. MERKLE</u>		
VR A15 (4) 30M REV. 1/68						

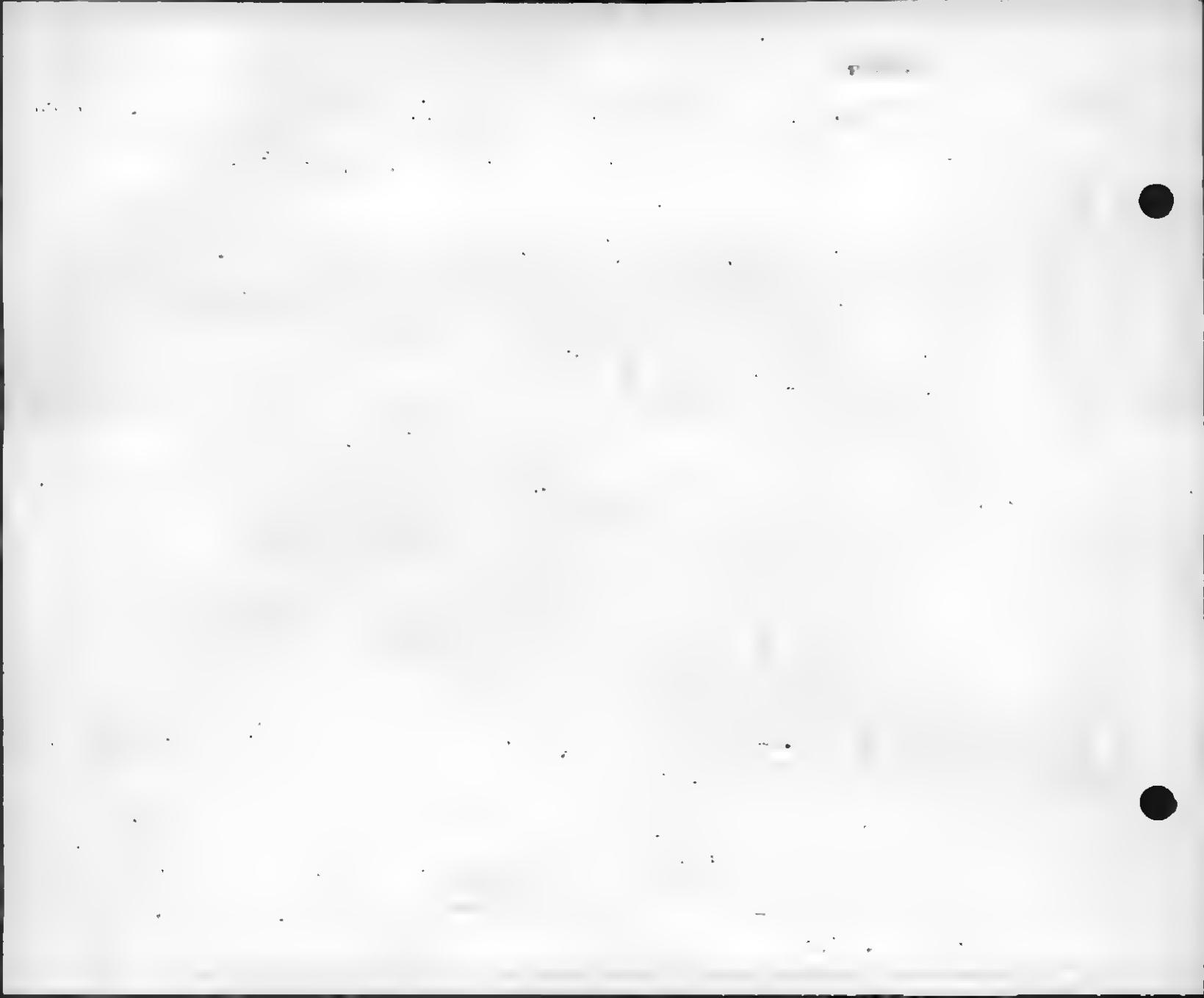


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

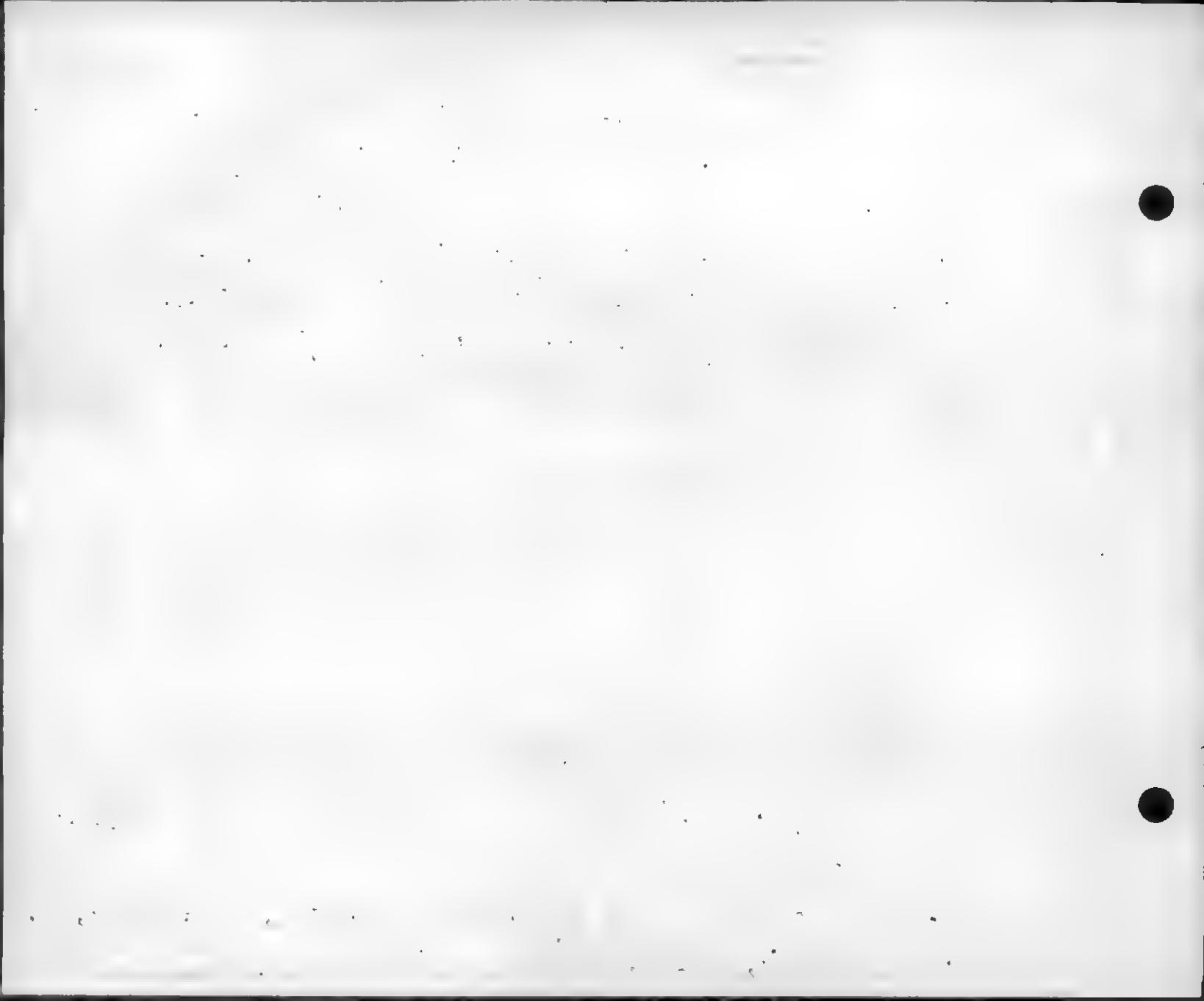
1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
<i>Helen Kenward Chapman</i>							Month <u>3</u> Day <u>18</u> Year <u>1968</u>	10:12 PM
3 SEX	4 RACE	5. DATE OF BIRTH			6 AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS <u>82</u> DAYS <u>0</u>	8. IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>	
Female	Caucasian	Feb 9 1886			82 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	Md		
ILLINOIS	U. S. A.				PRINCE GEORGE			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville	YATTSVILLE NURSING 6500 Riggs Rd. Home			Housewife			HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
DC	-	WASH DC	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3173 KERTER DC				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<i>Hunter</i>				<i>Kenward</i> HONORAH GILL				
16a. WAS DECEASED EVER IN U.S. ARMEED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.			17. INFORMANT	Address			
	370-32-4272			Lois HUGHTON	3173 KERTER ST. DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>ASHD</i> stating the underlying cause (c) <i>cardiogenic</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>hypomimetic CVA</i> <i>Cachexia</i>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from Aug 19, 1954, to 3/18, 1968, that (I) (we) last saw the deceased alive on 3/15 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>R.H. Sandstrom MD</i>				ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 3/18/68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS							
R.H. Sandstrom MD	7701 Carroll Ave. Takoma Park, Md							
23a. BURIAL, CREMATION, BURIAL REMOVAL (Specify)	23b. DATE 3-20-68	23c. NAME OF CEMETERY OR CREMATORIUM Grand Lawn Cemetery			23d. LOCATION (City or Town) Detroit, Mich.	(County)	(State)	
24. FUNERAL DIRECTOR Robert E. Wilhelm	ADDRESS 4308 Suitland Road Suitland Md.				25a. REC'D. BY REGISTRAR MAR 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		



CERTIFICATE OF DEATH

14530

1. DECEASED NAME (Type or print)	First Middle Last			2a. DATE OF DEATH Month Day Year	2b. HOUR 3 AM			
Tessie Chiczewski Chy		S. DATE OF BIRTH 9/20/89	6. AGE (In years lost birthday) 78 yrs.	F UNDER 18 MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.			
3. SEX F	4. RACE W	7. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH PRINCE GEORGE		
7a. BIRTHPLACE (State or foreign country) Poland		10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINEVIEW GARDENS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress	12b. KIND OF BUSINESS OR INDUSTRY STUART LYNNE
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE WASH. D.C.		13b. CITY OR TOWN PRINCE GEORGE, MARYLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 807 Erie St. SE		
14. FATHER'S NAME William XAKOWSK		Middle Lost	15. MOTHER'S MAIDEN NAME First PANKOWSKI ANNA			Middle Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 372-03-34525A			17. INFORMANT DAUGHTER	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIOVASCULAR COLAPSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PRE RENAL UREMIA DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22o. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> , 1968, to <u>3/20</u> , 1968, that (I) (we) last saw the deceased alive on <u>3/20</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Alfred R. Japen</i>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 3-20-68		
22d. PHYSICIAN'S NAME (Type) ALFREDO R. JAPEN		22e. ADDRESS CLINTON, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/22/68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCAT ON (City or Town) Suitland, Prince Georges, Md.	(County) (State)		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR DATE MAR 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Japen</i>			



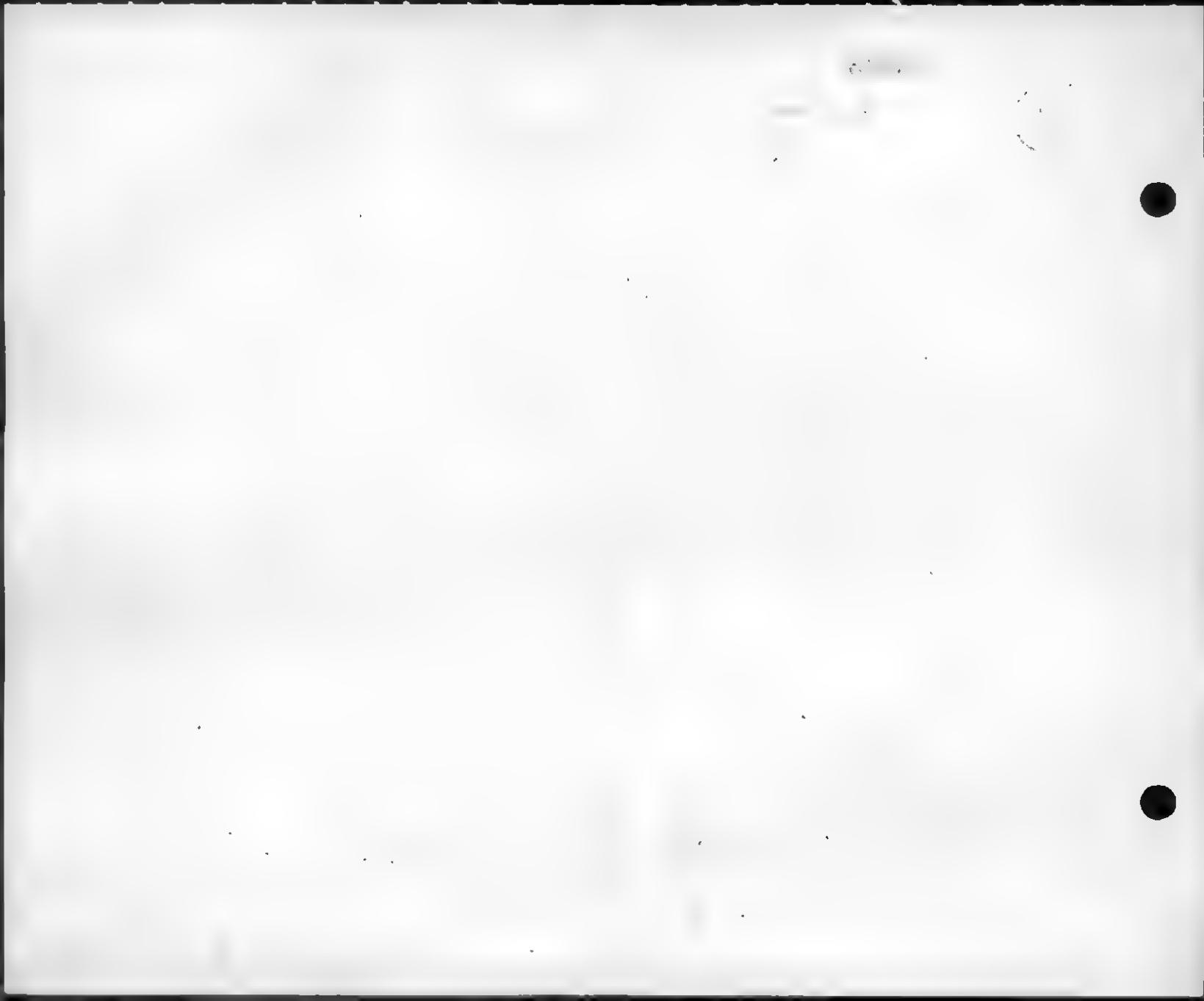
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH MATERIAL	Month	Day	Year	2b. HOUR		
3. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (In years (last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. MOJRS	10. MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done down most of working life even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dep't before admission) STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Drowned				few minutes				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO, OR AS A CONSEQUENCE OF				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR AM/PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)		21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21e. LOCATION Street or R.F.D. No. City or Town	
21f. AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21g. near Prince George Marvin		21h. State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)		DAYTON O WATKINS M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				March 29 68	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
Burial		April 1, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR		ADDRESS				25a. REG'D BY REG STRR		25b. REG STRR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.						APR 1 1968		Charles Judge			

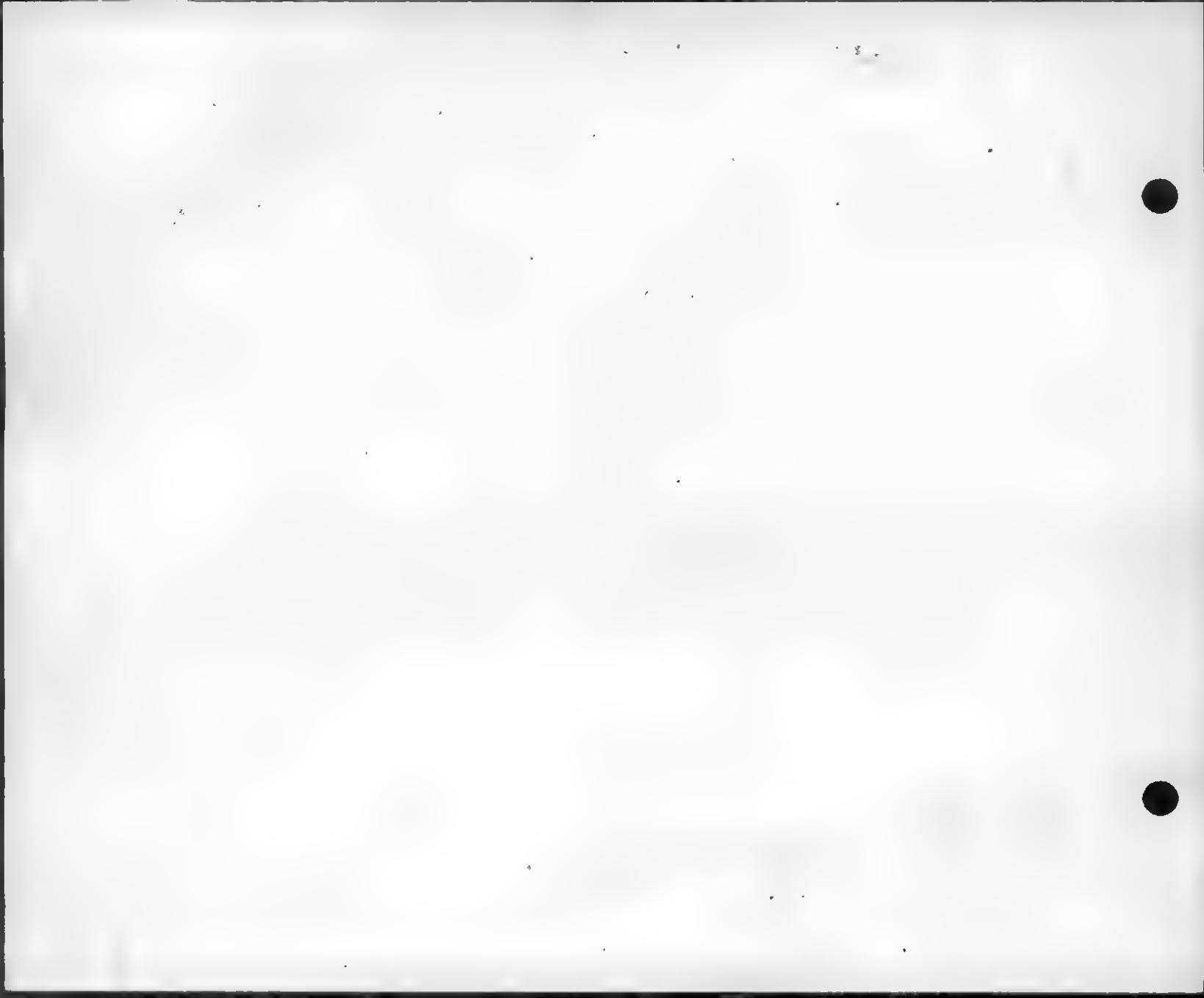


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with him. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI DEATH MATED			Month	Day	Year	
Steven Eugene Coddington						3	8	68	19	1:15 a.m.	2b HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR			
Hale	White	2-4-68	- YRS	MONTHS	DAYS	MONTH	DAY	YEAR	2d HOUR			
14						3	8	68	2:30 a.m.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED	9 NEVER MARRIED	9 COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY			
Wash., D.C.			USA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Prince George's			none			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret red)			12b KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Gen. Hospital			none			none			
13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE			13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Maryland			Prince George's Forestville	<input type="checkbox"/> NO <input type="checkbox"/>			7917 Penna. Ave.					
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MIDDLE NAME			First	Middle	Last	
David				Coddington		Ruby			Turner			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
no			none			David Coddington			Forestville, Md			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) 484X			Acute interstitial pneumonitis									
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) SDII									
			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 7630												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?						
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3-8-68			
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 3/10/68			23c NAME OF CEMETERY OR CREMATORIAL Steele Cemetery			23d LOCATION (City or Town) (County) (State) Friendsville, Md.			
Burial												
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Gerald N. Minnich			Oakland, Maryland			MAR 13 1968			Charles J. ...			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Baby	Middle Boy	Last Collins	2d. DATE OF DEATH Month March	Day 13,	Year 1968	2d. HOUR 9A. M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH March 12, 1968			6. AGE (In years lost birthday) YRS. 22	F. UNDER 1 YEAR MONTHS 22	I. F. UNDER 24 HRS. HOURS 19	M. MIN 19
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED XX	WIDOWED <input type="checkbox"/> DIVORCED XX	9. COUNTY OF DEATH Prince Georges			Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LUM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 57 I Ridge Rd.			
14. FATHER'S NAME Delbert L. Collins	First 	Middle 	Last 	15. MOTHER'S MAIDEN NAME Teresa Ann Slack	First 	Middle 	Last 	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown 	16b. SOCIAL SECURITY NO. 	17. INFORMANT 			Address 			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Atelectasis, bilateral							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
17b. d Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 							DUE TO, OR AS A CONSEQUENCE OF Respiratory Distress Syndrome (clinical)	
DUE TO, OR AS A CONSEQUENCE OF 							(b) 	
DUE TO, OR AS A CONSEQUENCE OF 							(c) 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 								
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 			20a. AUTOPSY? YES XX NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) 					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 	21f. LOCATION Street or R.F.D. No. 	City or Town 	County 	State 		
22a. I certify that () (physician) attended the deceased from March 12, 1968 , to March 13, 1968 , that () (XX) last saw the deceased alive on March 13, 1968 , and that in my () (XX) opinion death occurred on the date and hour and from the causes stated above, () (XX) () (XX) view the body after death 								
22b. SIGNATURE 		22c. DATE SIGNED March 14, 1968	DEGREE 	ATTENDING PHYS. 	MED. DIRECTOR XX	STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M.D.		22e. ADDRESS 6201 Riverdale Road, Riverdale, Maryland						
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) 		22b. DATE 3/16/68	23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. General Hosp.	23d. LOCAT. ON (City or Town) Cheverly, Maryland	(County) 	(State) 		
24. FUNERAL DIRECTOR William A. Parker, Assoc. Administrator		ADDRESS 			25a. REC'D BY REGISTRAR 	25b. REGISTRAR'S SIGNATURE Charles J. George		
VR A15 (4) 30M REV 1/68		DATE MAR 19 1968						

000000000000000000000000

3
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

35549
21544

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and (and) filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from page 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Pearl	Middle E.	Last Collins	2d. DATE OF DEATH Month March	2b. HOUR P Year 1968 1:25M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4-3-89		6. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0
7a. BIRTHPLACE (State or foreign country) W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Geo.			
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USLA RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Suitland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3701 Summer Rd.		
14. FATHER'S NAME Judson	First Sisler	Middle Emma	15. MOTHER'S MAIDEN NAME Blosser			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. 178-07-3647	17. INFORMANT Frank Swaney	Address , 3701 Summer Rd. Suitland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Cerebrovascular Collapse</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		<i>coronary infarction</i>				3 days
(c)		<i>Dribbles Spelitus</i>				2 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) <i>Arteriosclerosis generalized. Left hydronephrosis</i>						
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 1-31 , 1968, to 3-4 , 1968, that (I) (we) last saw the deceased alive on 3-4 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Alfred R. Lippman, MD</i>		22c. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 3/4/68			
22d. PHYSICIAN'S NAME (Type) Alfred R. Lippman, MD		22e. ADDRESS Clinton, MD				
23a. BURIAL, CREMATION, BURIAL (Specify)	23b. DATE 3/8/68	23c. NAME OF CEMETERY OR CREMATORIAL Smithfield Baptist Cemetery	23d. LOCATION (City or Town) Smithfield, Penna.	(County)	(State)	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home	25a. REC'D BY REGISTRAR MAR 8 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Jagger</i>				
4308 Suitland Road	Maryland					



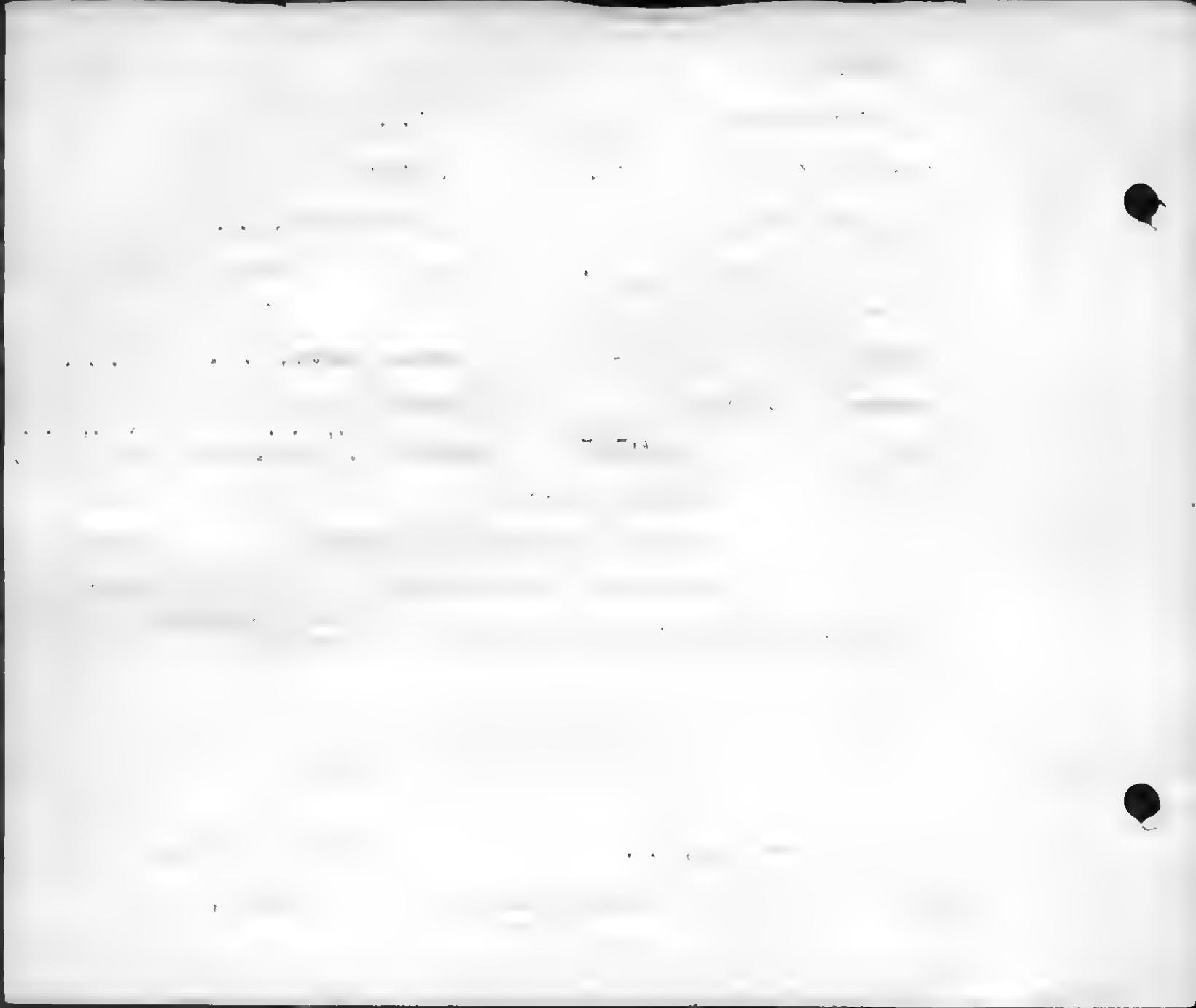
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

34550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE D.C.		b. COUNTY C	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 1 Yr. 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1242 5th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Huges		First	Middle T.	4. DATE OF DEATH March 11 1968	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1914	9. AGE (In years past birthday) 53 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Unknown Polkton, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Mack Crump		14. MOTHER'S MAIDEN NAME Unknown Wincy ??					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO 577-38-4960		17. INFORMANT Wash., D.C. Address (Decedent) Mr. Odes W. Cottingham (husband)		418 0st., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 5 Days	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) Coronary, arteriosclerotic disease				Unknown	
		DUE TO (c) Generalized arteriosclerosis				Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular accident, with right cerebral infarction, old, chronic pyelonephritis; bilateral hydronephrosis; left renal calculus						19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJRY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/3/1967 to 3/11/1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/11/1968 , and that death occurred at 1:55A.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 3/11/1968	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-16-68		23c. NAME OF CEMETERY OR CREMATORIUM Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Landover, Maryland	
24. FUNERAL DIRECTOR <i>Malvina Salley Inc.</i>		ADDRESS <i>424-3 St. Pkwy.</i>		25a. REC'D BY REGISTRAR MAR 15 1968		25b. REG STRR'S SIGNATURE <i>John S. ...</i>	
VR A15 (4) 25M 1/67							



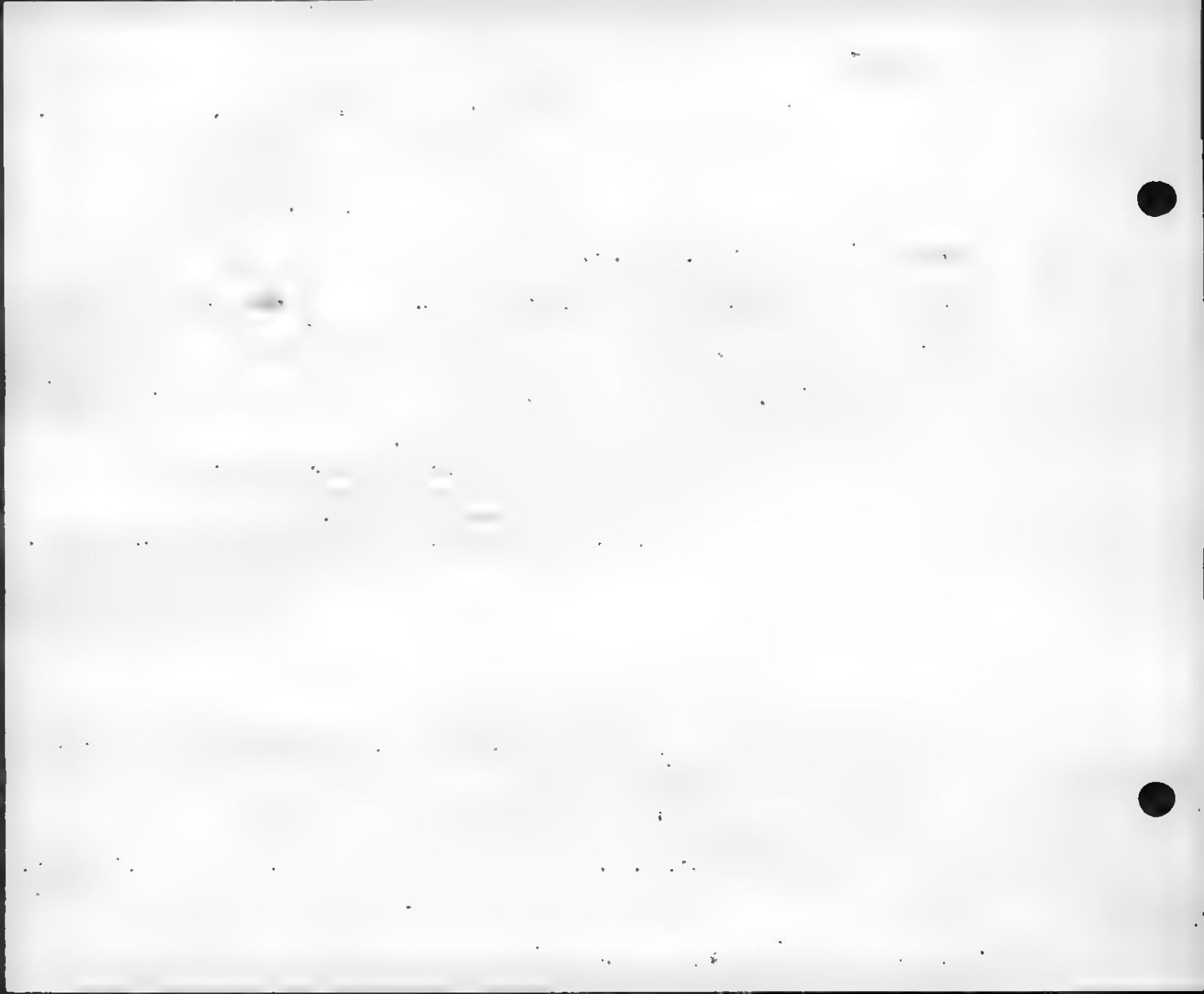
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Mary	Middle Covington	Lost	2a. DATE OF DEATH Month March	Year 21, 1968	2b. HOUR 2 P.M.
3. SEX Female		4. RACE Negroid		5. DATE OF BIRTH 10/25/68 1895	6. AGE (In years last birthday) 72	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) P.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XXX DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 60th Avenue		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. CITY OR TOWN Prince Georges		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 911 60th Avenue		
14. FATHER'S NAME First Harrison		Middle Syend	Lost	15. MOTHER'S MAIDEN NAME First Mary Fletcher			
16a. WAS DECEASED EVER IN U.S. ARMEO FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT 617dys Singleton		Address 911-60th Ave	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho-Pneumonia. 4 Due to, or as a consequence of (b) Severe Cerebral Arteriosclerosis with Thrombosis of the Basilar artery and the right Due to, or as a consequence of middle cerebral artery. (c) Infarction of the right occipital lobe and right cerebellum.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
		21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) Not while at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) At home		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.O. No. Prince Georges General Hospital	City or Town Cheverly		County Prince Georges	State Maryland
22a. I certify that (b) (this hospital) attended the deceased from March 6, 1968 to March 21, 1968 , that (b) (we) last saw the deceased alive on March 21, 1968 , and that in my our opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) not view the body after death.							
22b. SIGNATURE Edwin Jensen, M.D.		22c. DATE SIGNED 3/21/68	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) Edwin Jensen, M. D.		22e. ADDRESS Prince Georges General Hospital, Cheverly,					
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-26-68		23b. DATE 3-26-68	23c. NAME OF CEMETERY OR CREMATORIUM Synd Groves Eliebee N.C.		23d. LOCATION (City or Town) Maryland	(County) Maryland	
24. FUNERAL DIRECTOR H.S. Washington & Son 49357 Deale		ADDRESS Deale	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		

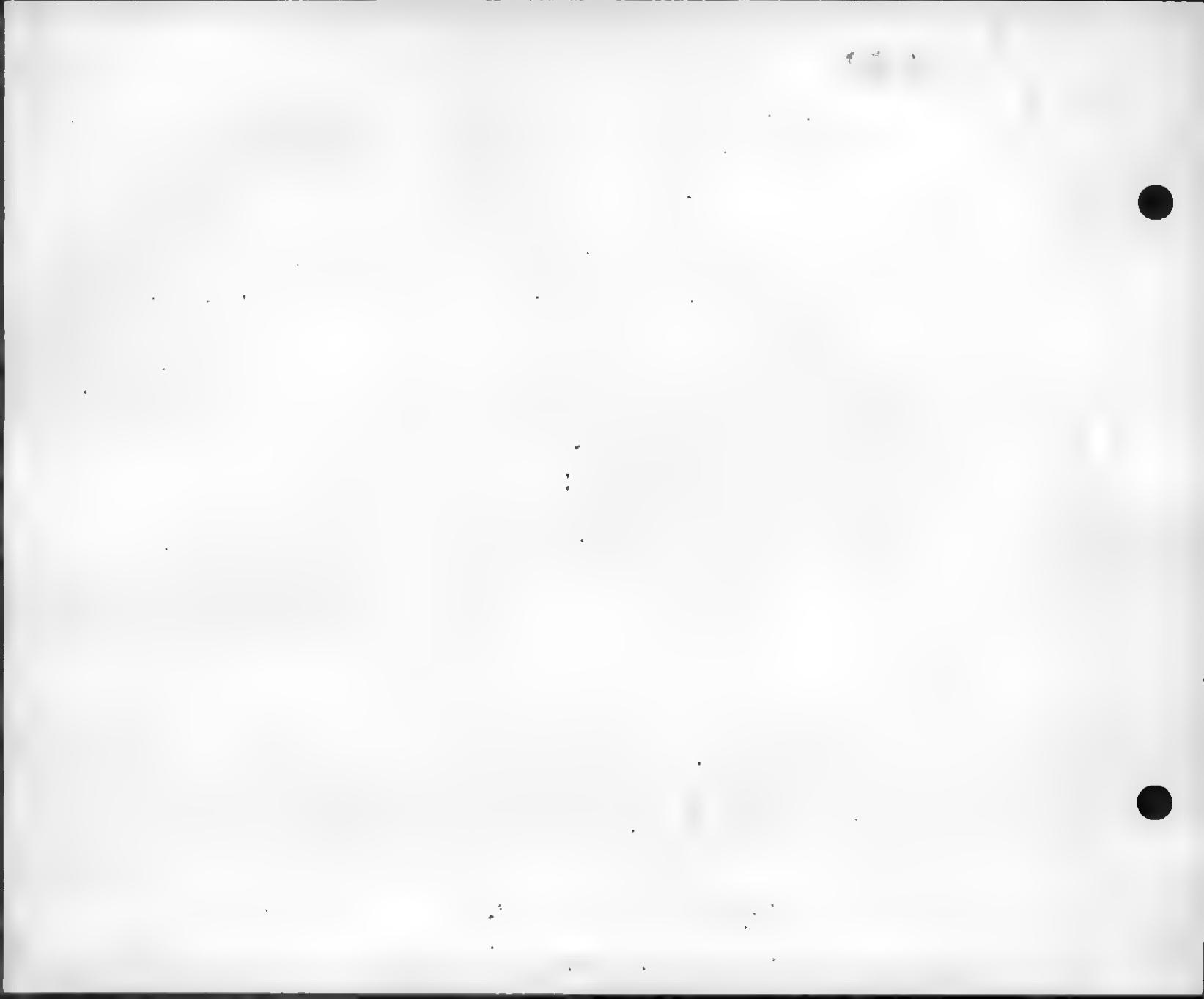


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Lillian</i>	Middle <i>Y.</i>	Last <i>Cross</i>	2a. DATE OF DEATH Month <i>March</i>	Day <i>10</i>	Year <i>1968</i>	2b. HOUR <i>11:53 P.M.</i>						
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>7-20-1890</i>			6. AGE (In years last birthday) <i>77 yrs.</i>		IF UNDER 1 YEAR MONTHS <i>7</i>		IF UNDER 24 HRS DAYS <i>26</i>		HOURS <i>11</i>	MIN. <i>53</i>		
7a. BIRTHPLACE (State or foreign country) <i>DC</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>PRINCE GEORGES Md</i>									
10. CITY OR TOWN OF DEATH <i>FORESTVILLE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>THE REGENT</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>D.C.</i>	13b. COUNTY <i>—</i>	13c. CITY OR TOWN <i>WASHINGTON</i>			13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>2427 Monroe St., N. E.</i>								
14. FATHER'S NAME First <i>—</i>	Middle <i>—</i>	Last <i>Woop</i>	15. MOTHER'S MAIDEN NAME First Middle <i>—</i>			Last <i>—</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>—</i>	16b. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>LILLIAN YOBST-5531 St. BARBARAS RD</i>			Address <i>Oxon Hill, MD</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Right renal</i> (arthritis)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several months</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c)												
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>180 X</i>														
19a. DATE OF OPERATION <i>2/5/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>—</i>									
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>—</i>			21f. LOCATION Street or R.F.D. No <i>—</i>		City or Town <i>—</i>		County <i>—</i>		State <i>—</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/10</i> , 19 <i>68</i> , to <i>3/10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3/10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Frederick H. Wilhite</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>3/10/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>James T. Ryans</i>		22e. ADDRESS <i>639 Lanover Rd., Cheverly, Maryland</i>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		23b. DATE <i>3/13/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>			23d. LOCATION (City or Town) <i>Smithland, Md.</i>		(County) <i>—</i>		(State) <i>—</i>			
24. FUNERAL DIRECTOR <i>James T. Ryans</i>		ADDRESS <i>313 Penn Ave.</i>			25a. REC'D BY REGISTRAR <i>MAR 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



FOR STATE
HEALTH DEPT.

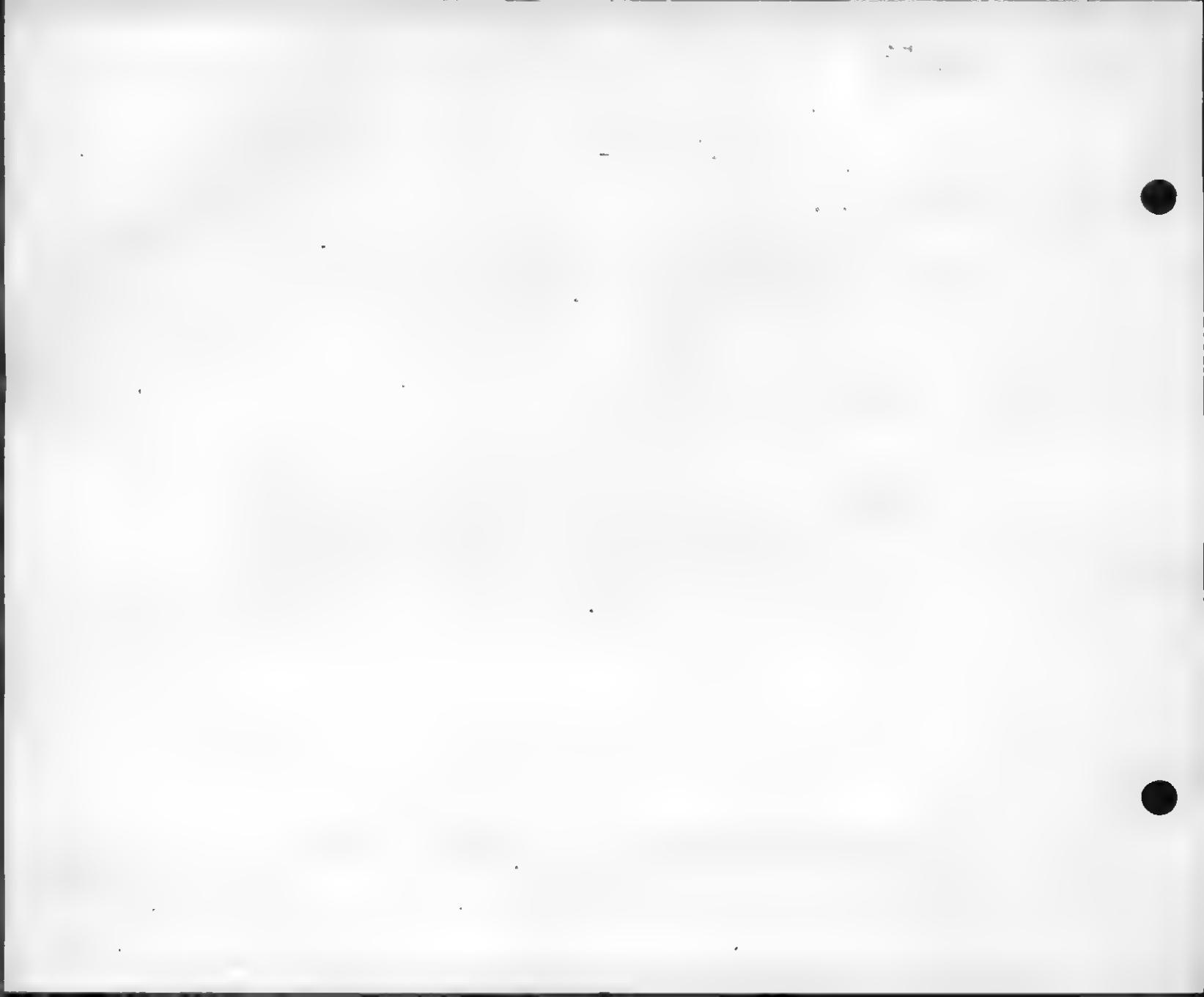
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First John	Middle Dominic	Last Crovo	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 3	Day 9	Year 1968	2b. HOUR 193:00 a.m.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1-18-1916	6. AGE (In years last birthday) 52 yrs	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. HOURS 0	10. MIN. 0			
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Prince George's				10d. M.D.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman				12b. KIND OF BUSINESS OR INDUSTRY Grocery
13a. USA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Mt. Rainier	13d. INS. OF CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 4621 Eastern Avenue					
14. FATHER'S NAME Dominic		Middle D.	Last Crovo	15. MOTHER'S M AIDEN NAME Estelle	16. --	Elliott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT John E. Crovo		5803 Quebec Street Berwyn Hts, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease								UNKNOWN
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last		(b) DUE TO, OR AS A CONSEQUENCE OF								
		(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4207		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
MEDICAL CERTIFICATION		21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED 3-10-68
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Riverdale, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-12-1968	23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Md.		(County)	(State)		
24. FUNERAL DIRECTOR Nalley Funeral Home		ADDRESS Mt. Rainier, Md.		25a. REC'D BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jolley</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

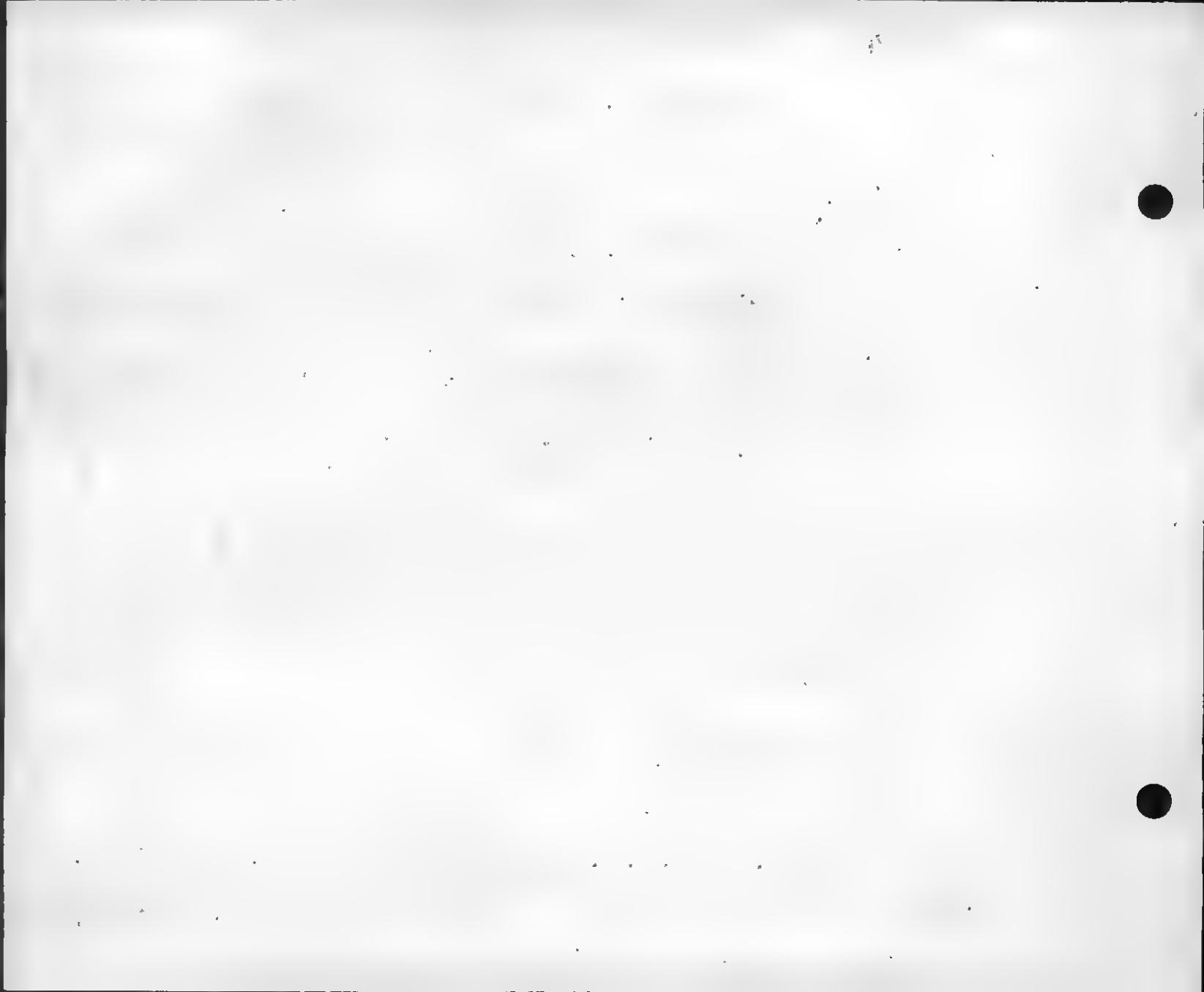
CERTIFICATE OF DEATH

1454

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Elizabeth	Middle W.	Last Daugherty	2a. DATE OF DEATH Month March	Doy 10, 1968	2b. HOUR 8:05 PM
3. SEX Female		4. RACE Caucasian		S. DATE OF BIRTH 5/27/1907	6. AGE (In years last birthday) 60 yrs		IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		12b. KIND OF BUSINESS OR INDUSTRY <i>Grocery Stores</i>
10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince Geo. Gen'l Hospital</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales Clerk</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4401 Queensberry Road
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13c. CITY OR TOWN PRINCE GEORGES COUNTY <i>Riverdale</i>		15. MOTHER'S MAIDEN NAME <i>unknown</i>		16. SOCIAL SECURITY NO <i>249-40-6325</i>	
14. FATHER'S NAME <i>unknown</i>						17. INFORMANT <i>F.DREXEL DAUGHERTY Same AS # 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the head of the Pancreas with</i> <i>widespread metastasis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>15;</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>XX</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) <i>(the deceased)</i> attended the deceased from <i>19</i> , to <i>March 10, 1968</i> , that (I) <i>(the deceased)</i> last saw the deceased alive on <i>March 10, 1968</i> , and that in (my) <i>(the deceased)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(the deceased)</i> did <i>(the deceased)</i> view the body after death.							
22b. SIGNATURE <i>Paul A. DeVore</i>		22c. DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	DATE SIGNED
22d. PHYSICIAN'S NAME (Type) <i>Paul A. DeVore, M. D.</i>		22e. ADDRESS <i>3415 Hamilton St. W. Hyattsville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>14 March 1968</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Washington National</i>		23d. LOCATION (City or Town) (County) <i>Saintland</i> (State) <i>Maryland</i>	
24. FUNERAL DIRECTOR <i>J.W. Chambers Co Riverdale, Md.</i>		ADDRESS		25a. REC'D. BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>James J. George</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-6-64
30M REV. 1/68

6255

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

J4549

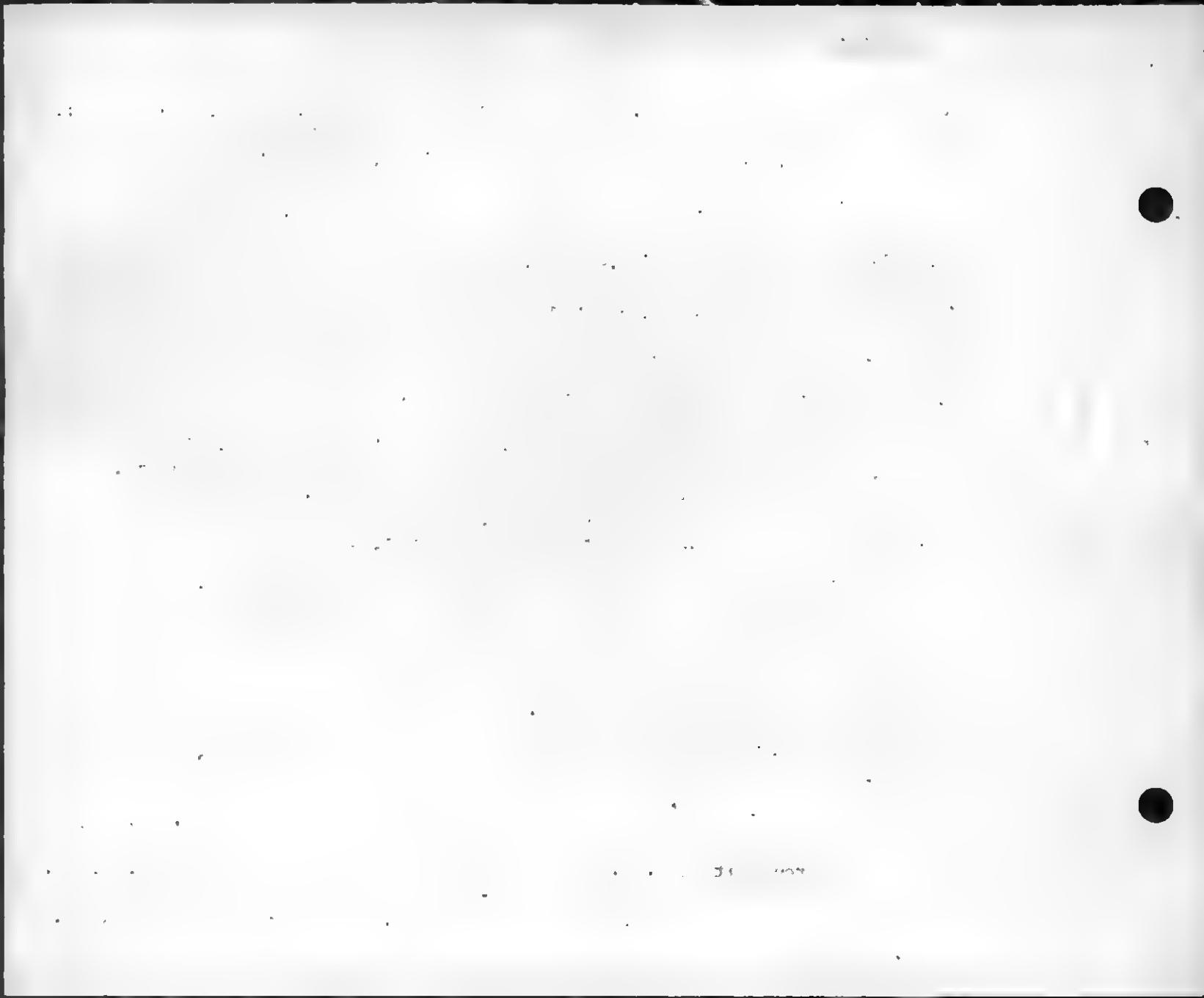
1. DECEASED NAME (Type or print)	First Baby	Middle Girl	Last Davis	2a. DATE OF DEATH Month March	Day 24 , 1968	Year 6:55 AM	2b. HOUR 6:55 AM
3. SEX Female	4. RACE Negroid	5. DATE OF BIRTH March 22, 1968		6. AGE (In years lost birthday) YRS		7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Cheverly	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5009 46th Avenue		
14. FATHER'S NAME Rudolph Edward Davis	First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary Kay Williams		Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mother		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) prematuity, 1050 GMS. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary atelectasis. bilateral. DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____	City or Town _____	County _____	State _____		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 22, 1968 to March 24, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 24, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Bernardo Alvarado, M. D.</i>	DEGREE MD	ATTENDING PHYS	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input checked="" type="checkbox"/>
22c. DATE SIGNED 3/26/68							
22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.	22e. ADDRESS Prince Georges General Hospital, Cheverly,						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/6/68	23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. Gen. Hospital	23d. LOCATION (City or Town) Cheverly, Maryland		(County) Maryland		
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator	ADDRESS	25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First Kyle	Middle W.	Last Dean	2a. DATE OF DEATH Month March	Day 21	Year 1968	2b. HOUR 9:10 P.M.			
3. SEX Male		4. RACE Caucasian			5. DATE OF BIRTH August 23, 1915		6. AGE (In years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		Md				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing						
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13c. CITY OR TOWN Prince Georges			13d. INS. DE CITY & MTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4703 68th Place						
14. FATHER'S NAME First IRVIN		Middle BEAN	Last MANLEY	15. MOTHER'S MAIDEN NAME First NOLA		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO 705-14-0483		17. INFORMANT Elizabeth J. Dean		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Myocardial Infarction of the left ventricle with mural thrombus.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 410.9		DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis of right coronary artery. DUE TO, OR AS A CONSEQUENCE OF (c) Infarction of right kidney due to (c) occlusion of right renal artery. 412.01											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Infarction of the spleen due to thrombosis of the splenic vein.													
MEDICAL CERTIFICATION	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) At home, farm, street, factory (OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No		City or Town		County	State		
22a. I certify that (1) Hospital attended the deceased from March 21, 1968 to March 21, 1968 , that (1) we last saw the deceased alive on March 21, 1968 , and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) not view the body after death.													
22b. SIGNATURE (L. Deitz, M.D.)	22c. DATE SIGNED March 22, 1968												
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Prince Georges Plaza, Hyattsville, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/27/68		23c. NAME OF CEMETERY OR Crematory Upshur & Memorial Park.			23d. LOCATION (City or Town) Buckhannon		(County) W. Va.		(State)			
24. FUNERAL DIRECTOR F. GASCH'S SONS	ADDRESS HYATTSVILLE, MARYLAND			25a. REC'D BY REGISTRAR MAP 26 1968		25b. REGISTRAR'S SIGNATURE W. Va. Judge							

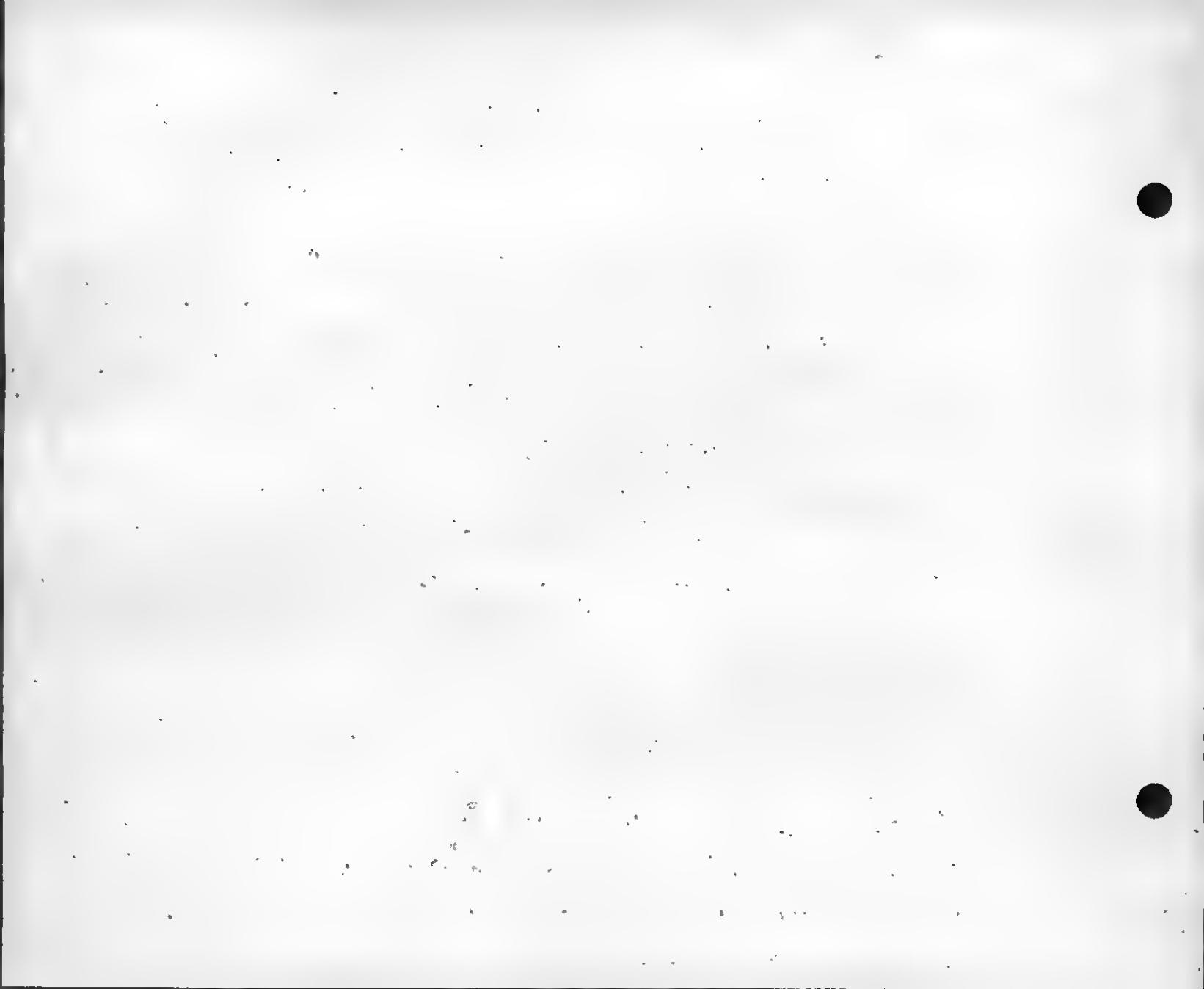


**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH <u>MARCH</u> Month <u>18</u> Day <u>1968</u>	2b. HOUR <u>3 P.M.</u>
Theodore		Detamore				
3. SEX male	4. RACE white	5. DATE OF BIRTH <u>June 11, 1908</u>		6. AGE (In years last birthday) <u>59</u> YRS	7. UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince Georges Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Forrestville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3707 82nd. Street
14. FATHER'S NAME First Robert		Middle Lee	Last Detamore	15. MOTHER'S MAIDEN NAME First Carrie		Middle Wisnom
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Mrs. Gladys W. Detamore, Forrestville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Occlusion</u> BETWEEN ONSET AND DEATH Died Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Occlusion</u> Died DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> 10 yrs						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of Esophagus</u> Palliative Resection Oct '67						
19a. DATE OF OPERATION <u>—</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 1958</u> to <u>March 1968</u> , that (I) (we) last saw the deceased alive on <u>March 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Edwin J. Dominick Jr.</u>						
22d. PHYSICIAN'S NAME (Type) KELVINE L. MURCHIN	22e. ADDRESS 6400 MARLBOROUGH SE WASH DC	22f. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22g. DATE SIGNED <u>3/18/68</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Purification	23b. DATE March 21, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery	23d. LOCATION (City or Town) Cambridge, Md.	(County) —	(State) —	
24. FUNERAL DIRECTOR Funeral Home Hyattsville Md.	ADDRESS —	25a. REC'D BY REGISTRAR MAR 20 1968	25b. REGISTRAR'S SIGNATURE James J. Gage			



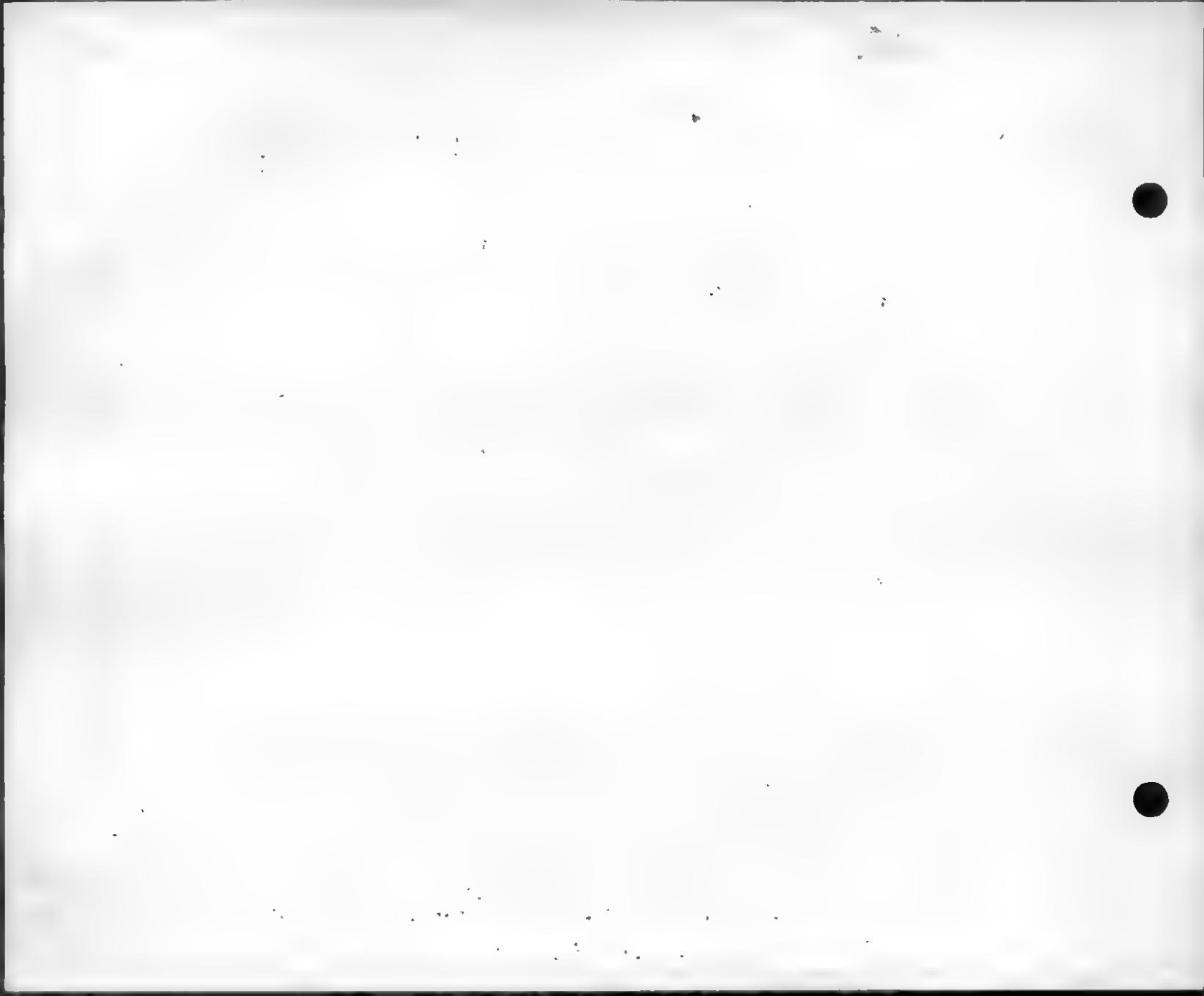
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

66558

158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b (the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	3 Day	2 Year	2b. HOUR 12:50 M		
3 SEX		F	4 RACE	N	S. DATE OF BIRTH	6 AGE (in years last birthday) 84 yrs.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		MD	7b CITIZEN OF WHAT COUNTRY?		U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Rural			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Upper Marlboro Md.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13c. CITY OR TOWN Pr. George Rural			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
14. FATHER'S NAME Clark			15. MOTHER'S MAIDEN NAME Unk.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO None			17. INFORMANT Mrs. Charity Curtis Upper Marlboro			Address Route - 301		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF 1st (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 493x Diabetes Mellitus											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from May , 1965, to March , 1968, that (I) (we) last saw the deceased alive on Feb 28 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3/2/68	
22b. SIGNATURE A. Clark Holmes M.D.										22d. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.	22e. ADDRESS Upper Marlboro, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-5-68		23c. NAME OF CEMETERY OR CREMATORIUM Resurrection			23d. LOCATION (City or Town) Clinton Md		(County) Clinton	(State) Md	
24. FUNERAL DIRECTOR Rollins 4339 - Hunt Pt N.E.		ADDRESS			25a. REC'D BY REGISTRAR MAR 6 1968			25b. REG. STRR'S SIGNATURE Charles Jones			
VR A15 (4) 30M REV 1/68											



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First Harry	Middle A	Last Dixon JR.	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 3	Day 9	Year 1968	2b. HOUR 7:50pm
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3 Feb. 1946	6. AGE (in years last birthday) 22 yrs	IF UNDER 1 YEAR MONTHS DAYS	F. UNDER 24 HRS. HOURS MIN				2d. HOUR 7:50pm
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md		2c. DATE PRONOUNCED DEAD Month 3 Day 9 Year 1968	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired). Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automobile			
13a. USUAL RESIDENCE (Where deceasedived institution Residence before admission) STATE Maryland		13c. CITY OR TOWN COUNTY Prince George		13d. INSIDE CITY - M 15? <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3421 55th. Avenue				
14. FATHER'S NAME First Harry A Dixon Sr		Middle	Last	15. MOTHER'S MAIDEN NAME First Edna I Duvall		Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 220 42 1365		17. INFORMANT Judith Ann Dixon		ADDRESS Lanham, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1 DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Laceration of brain</u></p> <p>Conditons if any, wh ch gave rise to immedioate cause (a), stating the underlying cause lost</p> <p>DUE TO, OR AS A CONSEQUENCE OF <u>Skull fracture</u></p> <p>(b) <u>From trauma - motorcycle accident</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>7154</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year Hour A.M. 4:46PM 3-9-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of motorcycle involved in collision					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 202 and Lottsford Road, Prince George County, Maryland		21f. LOCATION Street or R.F.D. No City or Town County State					
<p>22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>John Kehoe</u></p> <p>EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>22b. DATE SIGNED 3-10-68</p>									
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE March 13, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Pro Geo Md.		(County) (State)	
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REG STRAR DATE MAR 14 1968		25b. REG STRAR'S SIGNATURE <u>Charles</u>			



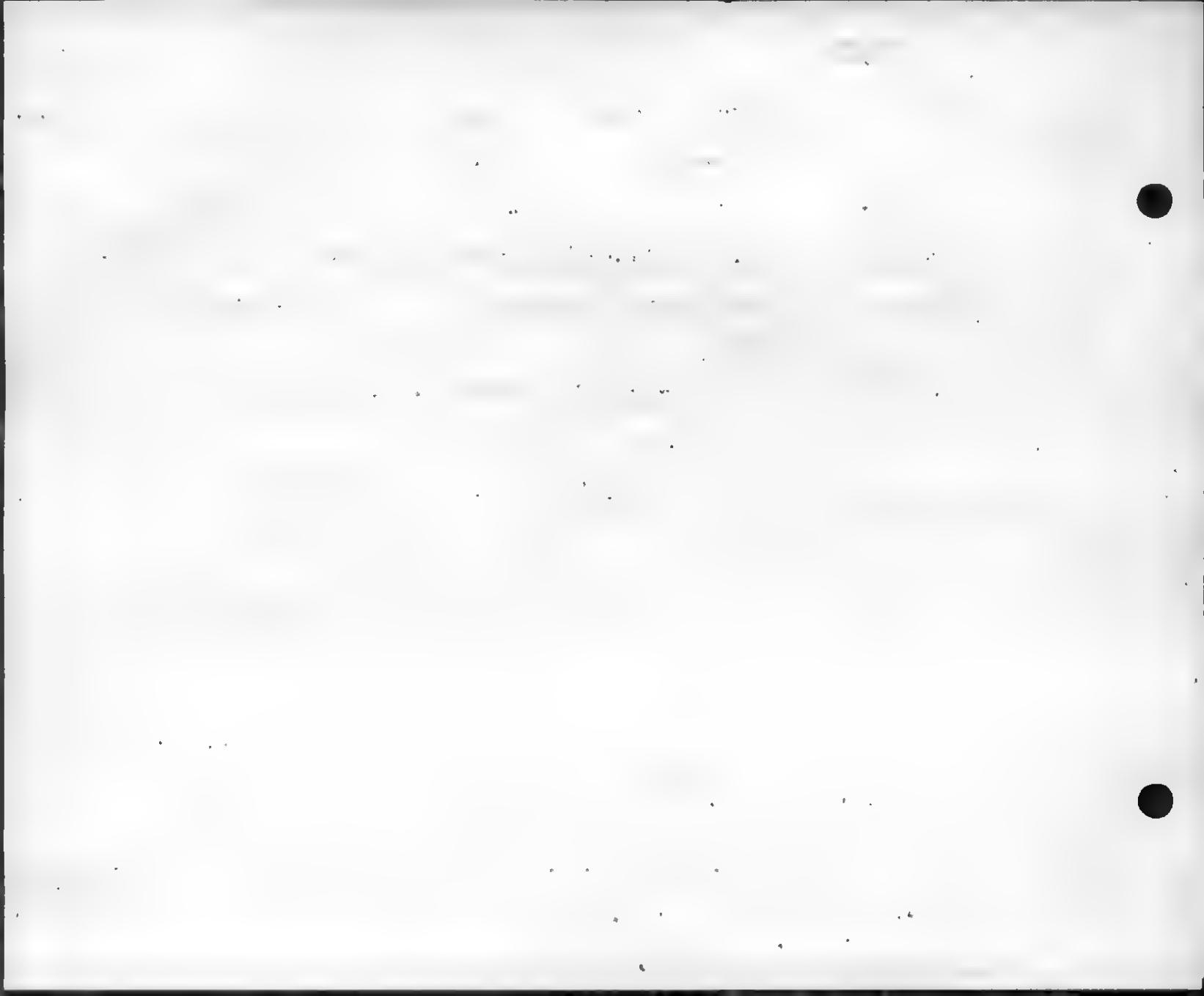
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First Lawrence	Middle Beaver	Last Dolby	2a. DATE OF DEATH Month March	Day 22, 1968	2b. HOUR 4 A.M.	
3. SEX Male		4 RACE Caucasian	5. DATE OF BIRTH March 12, 1888		6. AGE (in years last birthday) 80	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Prince Georges			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ramer		12b. KIND OF BUSINESS OR INDUSTRY Farm		
13a. U.S. RESIDENCE (Where deceased lived, if institution, residence before admission) Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Morningside	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 306 Boxwood Drive			
14. FATHER'S NAME First Joseph Dolby		Middle Last	15. MOTHER'S MAIDEN NAME First Mary Heaver					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 226-44-8340T	17. INFORMANT Lawrence B. Dolby		Address Same As 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		CARDIOGENIC SHOCK.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE 5 YEARS						
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 17, 1968 to March 22, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 22, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> did not view the body after death.								
22b. SIGNATURE <i>Norman K. Bohrer, M.D.</i>				22c. DATE SIGNED March 22, 1968				
22d. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M. D.		22e. ADDRESS Prince Georges General Hospital, Cheverly,						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/25/68	23c. NAME OF CEMETERY OR CREMATORIAL Wash. National Cemetery		23d. LOCATION (City or Town) Suitland, Prince Georges, Md.	(County) Maryland		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. RECD BY REGISTRAR DATE MAR 26 1968	25b. REGISTRAR'S SIGNATURE <i>James J. Geiger</i>			

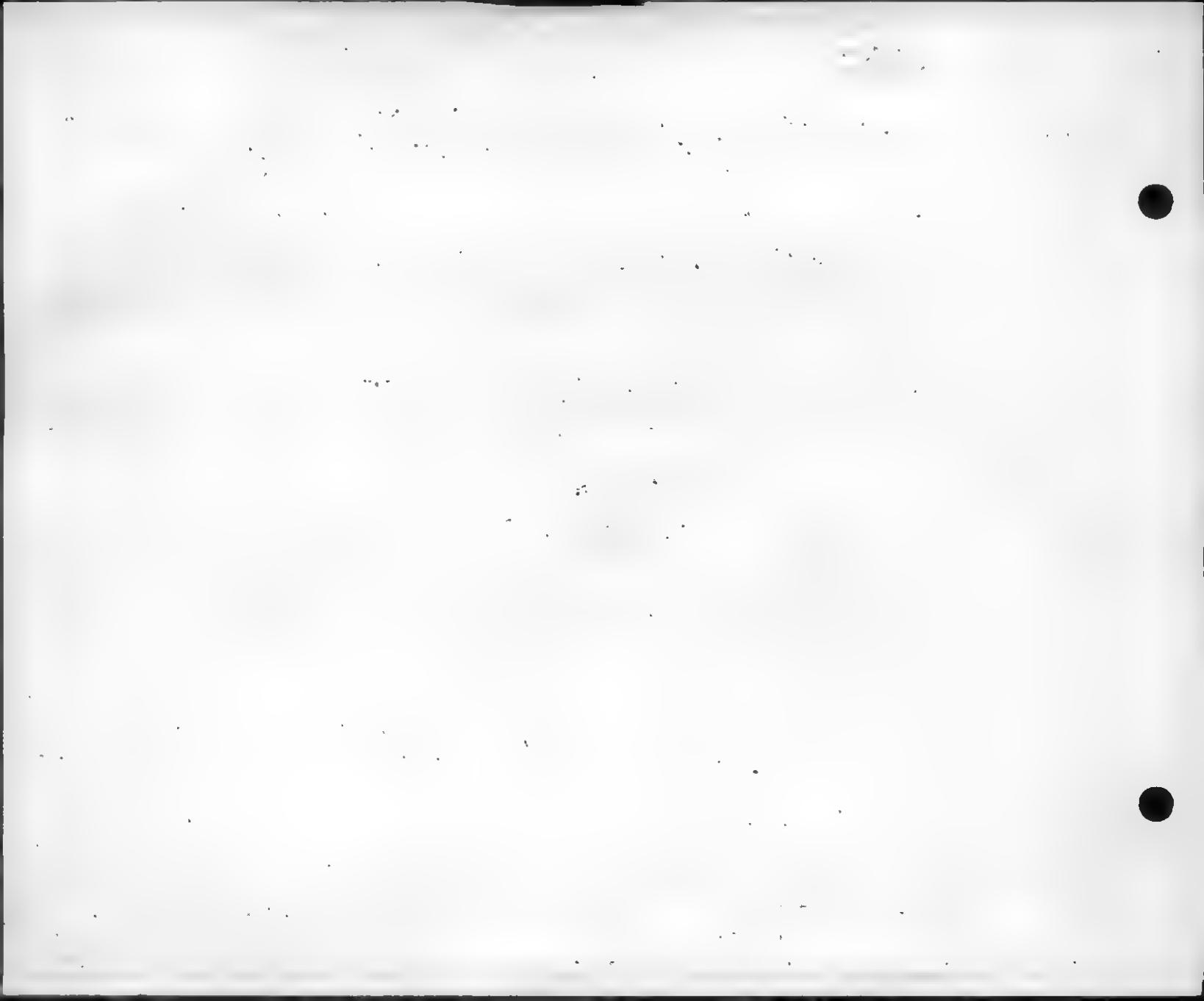


CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM/PM		
LILLIAN M DURNROUGHT				3 30 68	12:30 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
F	W	10/15/86	81				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED WIDOWED	9 COUNTY OF DEATH	Md			
VA.	U.S.A.	<input checked="" type="checkbox"/> DIVORCED	P. G. COUNTY				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
CLINTON, MD.	PINEVIEW GARDENS			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMIT?	13e. STREET AND NUMBER			
MD.	P.G.	Forrestville	YES <input type="checkbox"/> NO <input type="checkbox"/>	3309 Winter Green Avenue			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO	17. INFORMANT	Address			
NO		213-54-5539	DAUGHTER				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ACUTE MYOCARDIAL (HEART) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		MINUTES					
DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY DISEASE		YEARS					
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS.		YEARS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
4109.							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
		22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-29-67 to 3-30-68, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3-30-68, and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.				22c. DATE SIGNED 3-30-68	
22b. SIGNATURE R. L. Lew, M.D.		22d. PHYSICIAN'S NAME (Type) RALPH LEW, M.D.		22e. ADDRESS PINEVIEW GARDENS			
23a. BURIAL, CREMATION, REMOVAL BODY	23b. DATE 4-2-68 4-3-68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland, PG	(County) Md.		(State)	
24. FUNERAL DIRECTOR	Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. SE Washington, D.C.		25a. REC'D BY REGISTRAR DATE APR 3 -	25b. REGISTRAR'S SIGNATURE 1968 Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

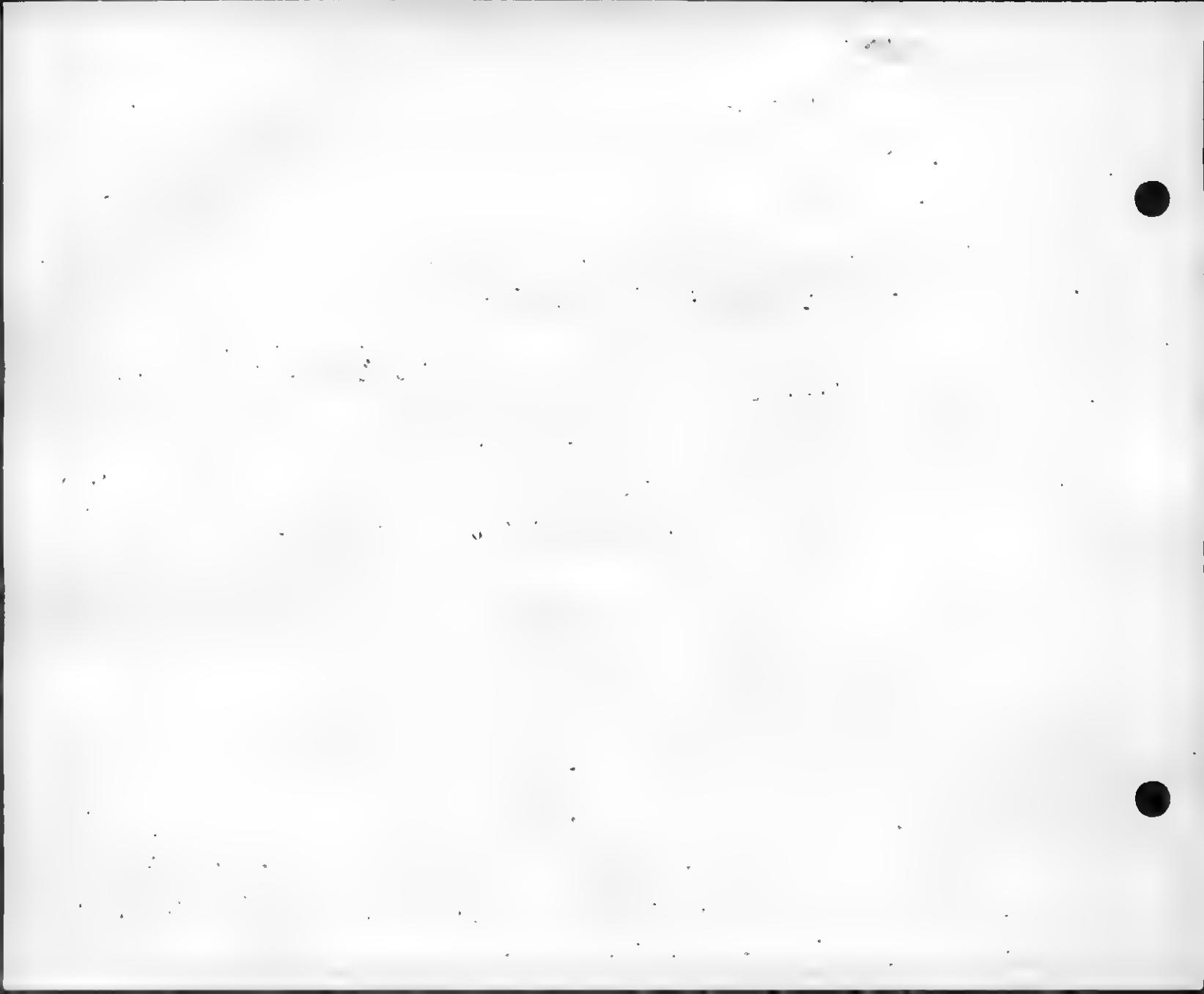
556

62

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Cleo James	Middle Edwards	Lost	2a. DATE OF DEATH Month MARCH	Day 22	Year 1968	2b. HOUR 11P M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR MONTHS 0	DAYS 0	HOURS 00	IF UNDER 24 HRS. MONTHS 0
7a. BIRTHPLACE (State or foreign country) NEBRASKA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S				
10. CITY OR TOWN OF DEATH RIVERDALE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ELAND MEM HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) GUARD		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13c. CITY OR TOWN PRINCE GEORGE'S		13d. INSIDE CITY LIMITS Renovated	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4310 40th St.		
14. FATHER'S NAME CHARLES	First	Middle	Last	15. MOTHER'S MAIDEN NAME MARY M. JONES	First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO 578240186		17. INFORMANT MRS EDNA M. EDWARDS	Address SAME AS #13			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 5 yrs</p> <p>(b) HYPERTENSIVE CARDIO VASCULAR DISEASE</p> <p>DUE TO, OR AS A CONSEQUENCE OF 2 YEARS</p> <p>(c) CORONARY VASCULAR SCLEROSIS</p>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 1950, to MARCH, 1968, that (I) (we) last saw the deceased alive on 10-27-67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Benjamin S. Miller MD		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-25-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 3824 34th St. Mt Rainier						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 26 Mar. 1968		23c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEM		23d. LOCATION (City or Town) COLMAR MANOR, MARYLAND		
24. FUNERAL DIRECTOR W.W. CHAMBERS & RIVERDALE, MD		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

34563

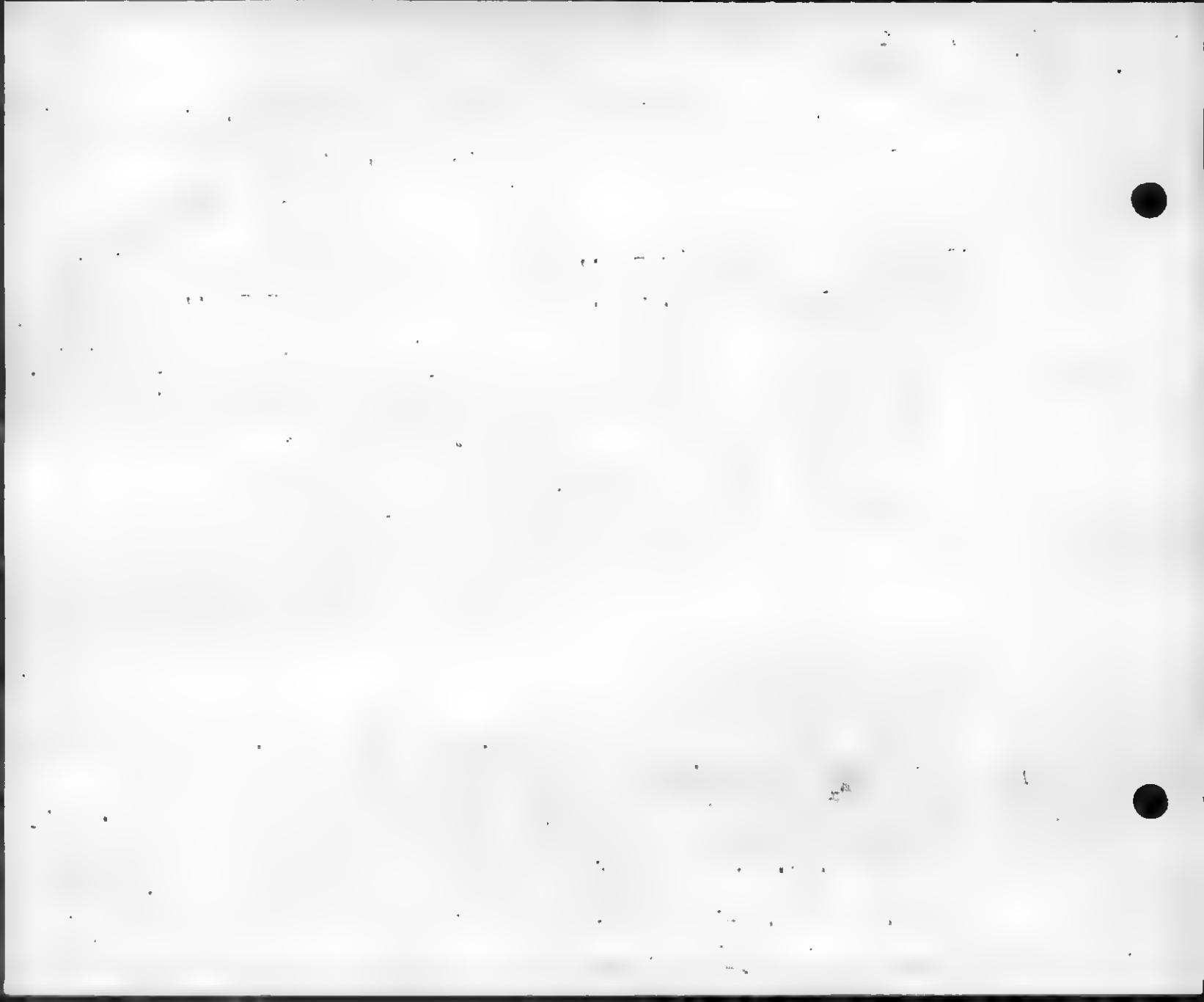
1.

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First THERESA	Middle DOROTHY	Last FITING	2d. DATE OF DEATH Month Mar. Day 21 Year 1968	2b. HOUR AM 6:30
3. SEX Female		4. RACE White		S. DATE OF BIRTH Dec. 23rd, 1912	6. AGE (In years lost birthday) 55 yrs.	
7a. BIRTHPLACE (State or foreign country) Washington DC		7b. CITIZEN OF WHAT COUNTRY? White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George	
10. CITY OR TOWN OF DEATH Hillside		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5803-L-St., SE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none
13a. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE Maryland		13c. CITY OR TOWN Pr. Geo. Hillside		13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5803-L-St., SE	
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Giovinazzo		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		Address Hillside Md.
				16b. SOCIAL SECURITY NO.		17. INFORMANT Sister Katie Petro
						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4120 Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last
						Cerebral Hemorrhage
						Approximate interval between onset and death 5 Hrs
						Hypertensive Arterosclerotic Cardio Vascular Disease
						10 yrs
						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1142
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from Mar. 8, 1968, to Mar. 21, 1968, that (I) (we) last saw the deceased alive on Mar. 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.						
22b. SIGNATURE Dr. R. J. Terrafranca		22c. DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED Mar. 21-1968
22d. PHYSICIAN'S NAME (Type) Dr. R. J. Terrafranca		22e. ADDRESS #8 Barney Circle SE Wash DC				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 25-1968		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Maryland (County) (State)
24. FUNERAL DIRECTOR Commons Bros. Simmons Bros. 1661-Good Hope Rd SE		ADDRESS Wash DC		25a. REC'D BY REGISTRAR MAR 26 1968	25b. REGISTRAR'S SIGNATURE newis judge	
				DATE		

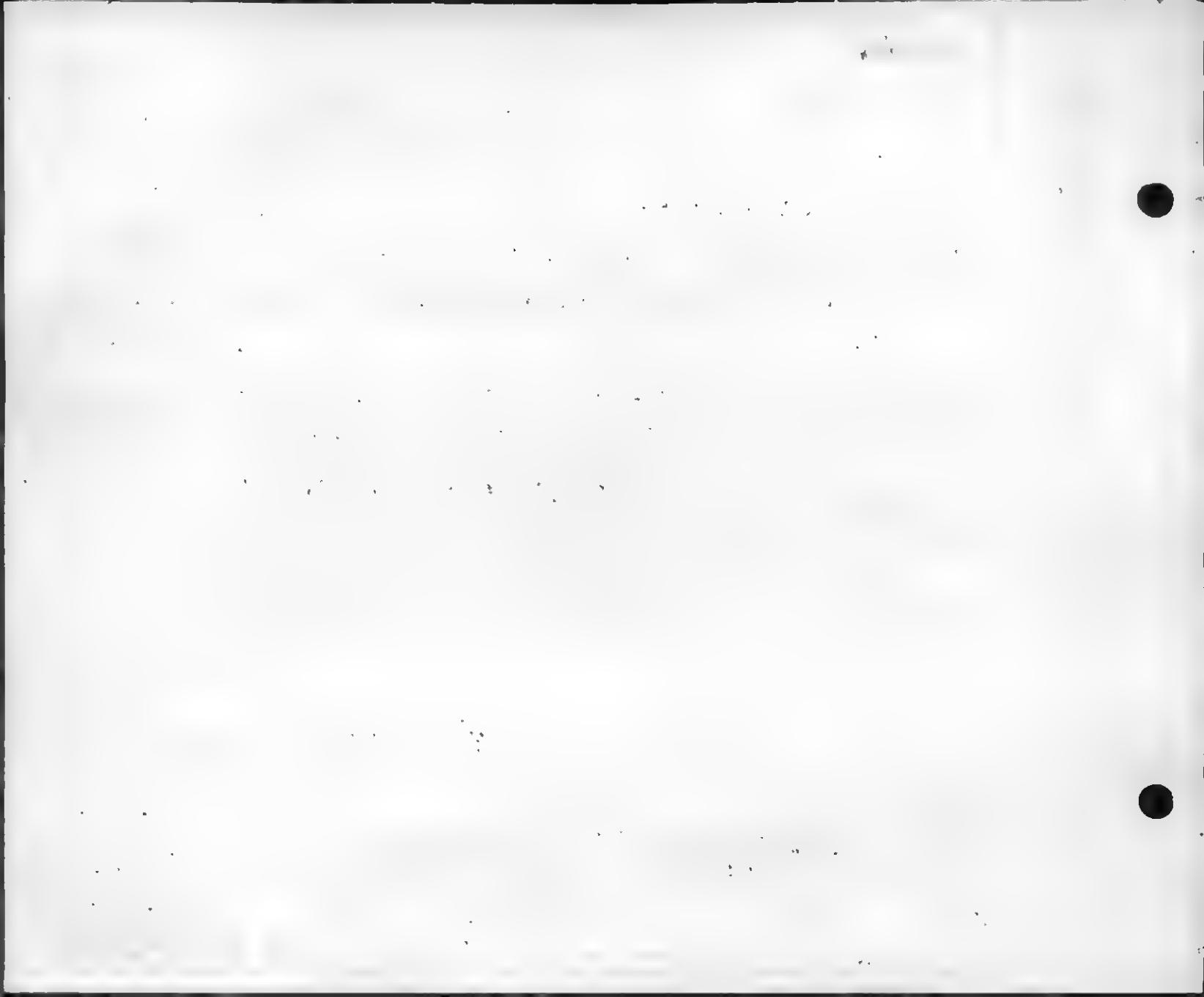


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. **10** **3** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21** **22** **23** **24** **25** **26** **27** **28** **29** **30** **31** **32** **33** **34** **35** **36** **37** **38** **39** **40** **41** **42** **43** **44** **45** **46** **47** **48** **49** **50** **51** **52** **53** **54** **55** **56** **57** **58** **59** **60** **61** **62** **63** **64** **65** **66** **67** **68** **69** **70** **71** **72** **73** **74** **75** **76** **77** **78** **79** **80** **81** **82** **83** **84** **85** **86** **87** **88** **89** **90** **91** **92** **93** **94** **95** **96** **97** **98** **99** **100**

1. DECEASED NAME (Type or print)		First Lillian	Middle Erskine	Last	2a. DATE OF DEATH Month March	Day 27	Year 1968	2b. HOUR p.m. 1:50
3. SEX Female	4 RACE White	5. DATE OF BIRTH July 7, 1871			6. AGE (In years last birthday) 96 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 1	MIN 0
7a. BIRTHPLACE (State or foreign country) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? United States	8 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Prince George			Md	
10 CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerical			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE District of Columbia	13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2101 -16th St. N.W.				
14 FATHER'S NAME First John	Middle Erskine	Last	15 MOTHER'S MAIDEN NAME Catherine	First Thayer	Middle Walker	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 579-44-2052	17 INFORMANT Sacred Heart Home, Hyattsville, Maryland			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 41a7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs		
(b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 41a8								
19a. DATE OF OPERATION 4/22/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING IF either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 17, 1958</u> , to <u>Mar 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>Mar 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE F. P. Guayle, M.D.		ATTENDING PHYS	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED 3/27/68
22d. PHYSICIAN'S NAME (Type) F. P. Guayle		22e. ADDRESS 1822 18th Street NW Washington DC						
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)	23b. DATE Mar. 29, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Newton Cemetery	23d. LOCATION (City or Town) (County) Newton Center Mass.					
24. FUNERAL DIRECTOR H. Don. DeVol	ADDRESS 2222 Wisconsin Ave. N.W.	25a. REC'D BY REGISTRAR DATE MAR 29 1968	25b. REC'D BY CLERK SIGNATURE Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

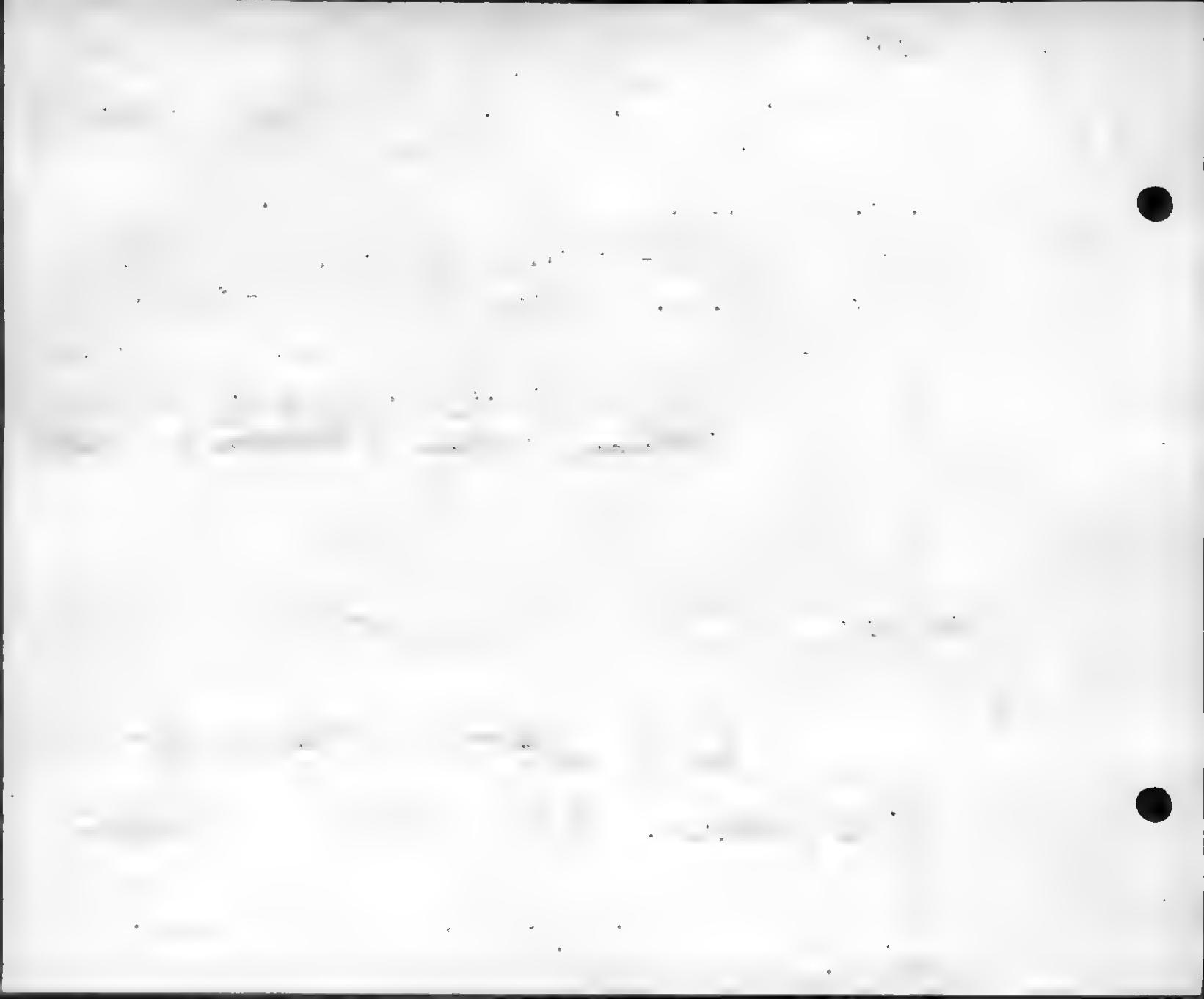
65

3455

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Robert	Middle O.	Last Evans	2a. DATE OF DEATH Month May Day 18 Year 1968 2b. HOUR 9:30 AM	2b. HOUR	
3 SEX Male	4 RACE White	5. DATE OF BIRTH 3/3/1921		6 AGE (In years at birth) 47 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 9	MIN 30
7a. BIRTHPLACE (State or foreign country) S.Car.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr.Geo.			
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 9210 - 6th St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engr.Glendale Hosp.		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Pr.Geo.	13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9210 - 6th St.		
14. FATHER'S NAME William	Middle Evans	15. MOTHER'S MAIDEN NAME Louellar		Address Brooks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. WWII	17. INFORMANT Mrs.Vera S.Evans (Above address)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(Wife) Concussion at Young C Mortuary 3 Morties		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO, OR AS A CONSEQUENCE OF		(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION Oct 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input checked="" type="checkbox"/> If either, notify medical examiner		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 2</u> , 1967, to <u>May 18</u> , 1968, that (I) (we) last saw the deceased alive on <u>May 14</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. L. Nalley</i>		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/18/68	
22d. PHYSICIAN'S NAME (Type) Nalley's Funeral Home Inc.		22e. ADDRESS Ft. Lincoln Cem. Mt. Rainier Maryland					
23a. BURIAL, CREMATION, REMOVAL Specified Burial		23b. DATE 3/21/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Rainier Maryland		23d. LOCATION (City or Town) Colmar Manor Md	(County) (State)	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>J. L. Nalley</i>			



FOR STATE
HEALTH DEPT

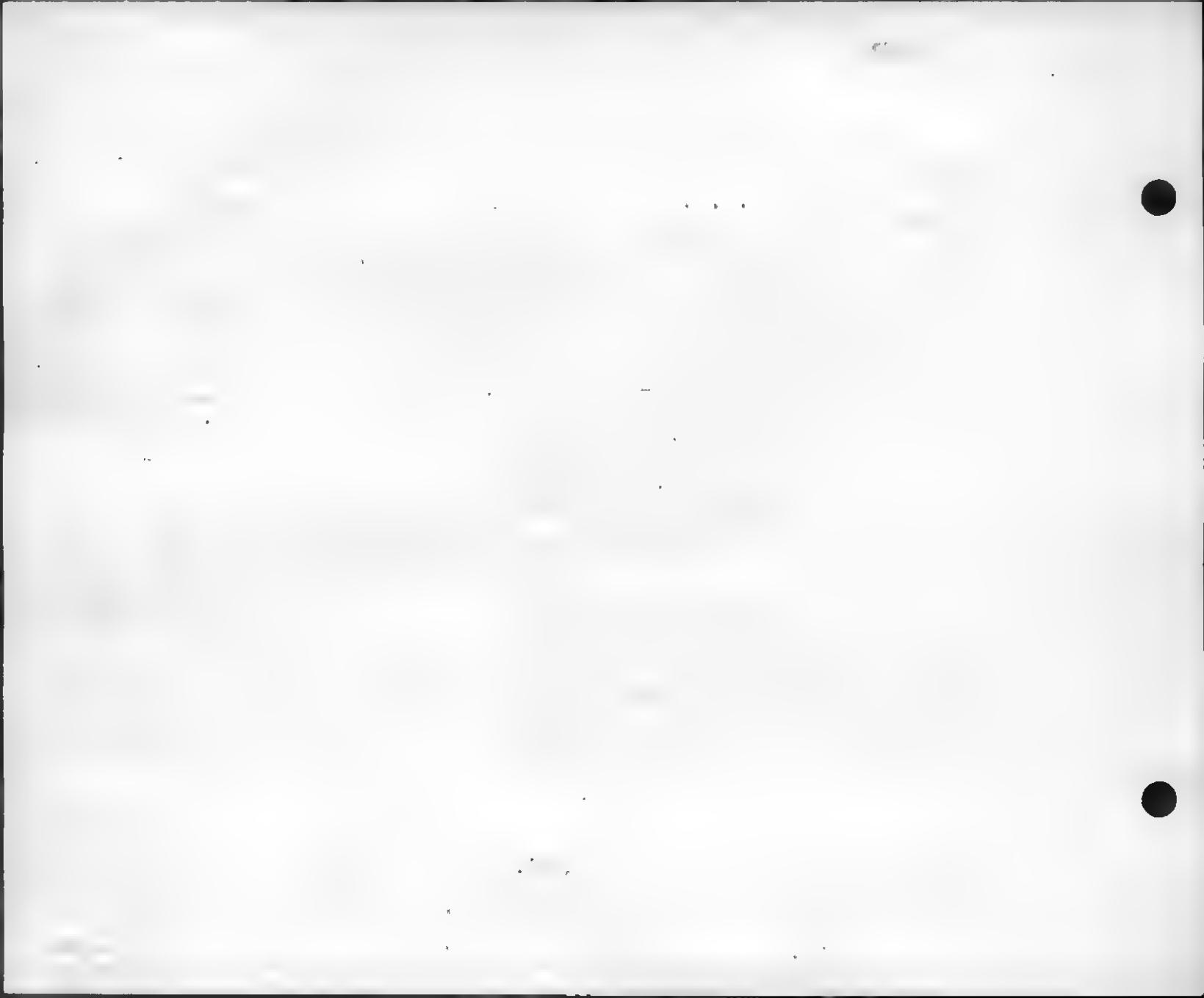
1
64568
Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pengel, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3-15-68 1968 00am	2b. HOJR		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR <input type="checkbox"/> MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR		
Female	White	5-21-1914	53 YRS	<input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3 15 1968 9:41am M			
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Prince George's</u>			
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Ret. Waitress</u>			
13a. USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Prince George</u>		13c. CITY OR TOWN <u>Suitland</u>	13d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <u>5613 Shady Side Avenue</u>		
14. FATHER'S NAME First <u>William</u>		Middle <u>Henry</u>	Last <u>Swann</u>	15. MOTHER'S MAIDEN NAME First <u>Mary Emma Smoot</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16b. SOCIAL SECURITY NO. <u>578-26-9987</u>		17. INFORMANT <u>Mr. Mary E. Gignac - pl., Riverdale,</u>		ADDRESS <u>5409 - Morton</u> Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Rheumatic valvular heart disease over 3 yrs					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <u>With mitral stenosis</u>						
		(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accidental <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Johy Keh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22b. DATE SIGNED <u>3-16-68</u>	
EXAMINER'S NAME (Type) <u>John Kehoe MD</u>		ADDRESS (Street, city, town, or county) <u>Riverdale, Md.</u>						
23a. BURIAL CREMATION, REMOVAL. (Specify) <u>Burial</u>		23b. DATE <u>3/18/68</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill Cem.</u>		23d. LOCAT.ON (City or Town) (County) (State) <u>Suitland, Md.</u>		
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Juge</u>		



FOR STATE
HEALTH DEPT.

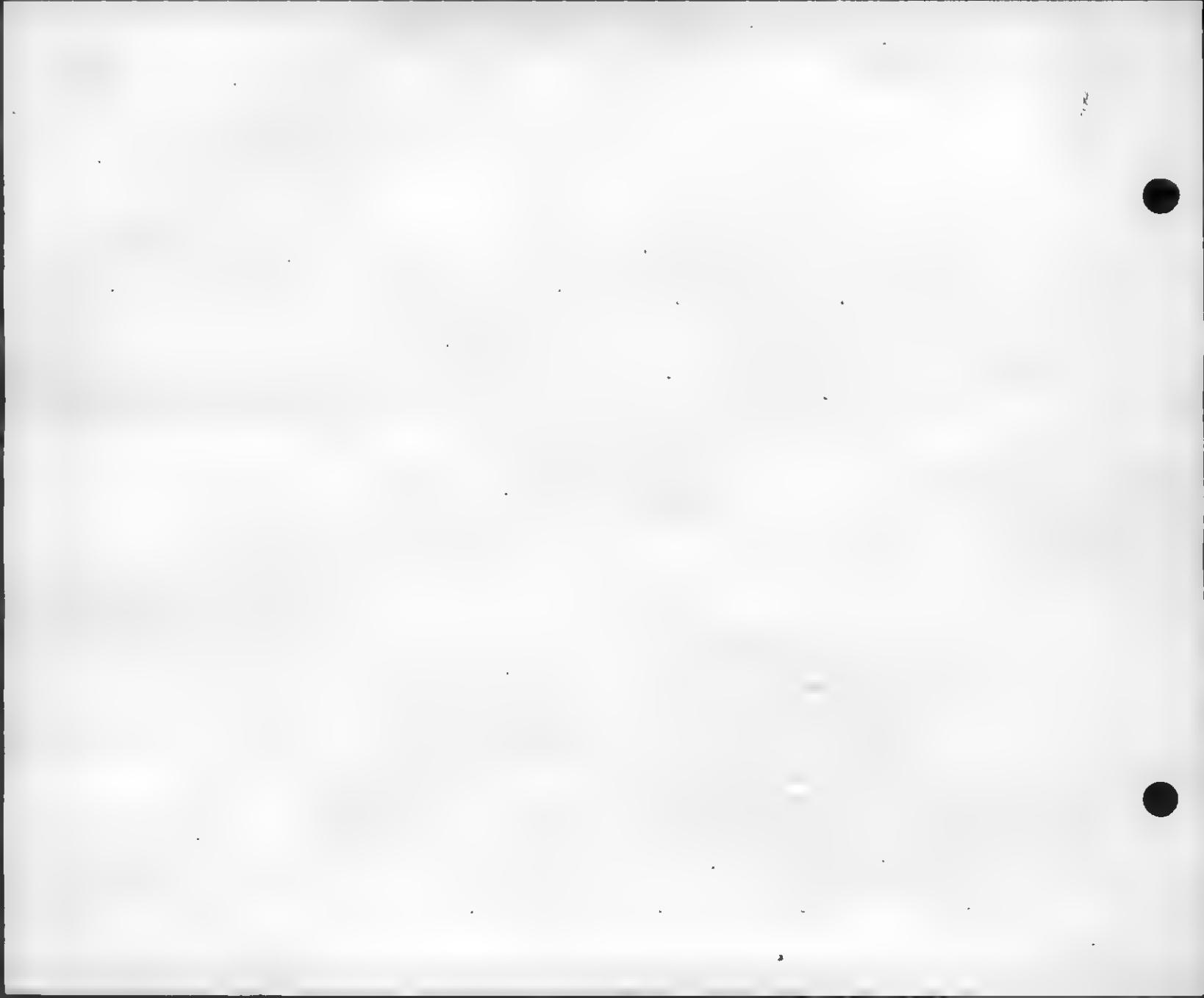
any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M.A. page
5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
It is 26th of March, 1968, at 11:00 A.M.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First Jesse	Middle Kose	Last Ferrell	2a DATE KNOWN OF DEATH ESTIMATED MATERIAL	Month 3	Day 14	Year 1968	2b HOUR P.M. 1:10
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday) 56	7 IF UNDER 1 YEAR MONTHS YRS	8 IF UNDER 24 HRS HOURS MIN				
7a BIRTHPLACE (State or foreign country) N. CAROLINA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's		2d HOUR P.M. 1:30	
10. CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 11406 Hennies Driv			12a. USA. OCCUPATION (Kind of work done during most of working life even if retired) TAXI CAB DRIVER			12b. KIND OF BUSINESS OR INDUSTRY AMERICAN CAB CO.	
13a. USAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE Md.		13c CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 11406 Hennies Driv			
14. FATHER'S NAME GEORGE		Middle FERRELL	Last FERRELL	15. MOTHER'S MAIDEN NAME UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 223-05-5135		17. INFORMANT Ferrell		ADDRESS 11406 HENNESSY DR BELTSVILLE, MD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Arteriosclerotic Heart Disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Nease H.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-17-68	
EXAMINER'S NAME (Type) John Nease H.D., Riverdale, Maryland		ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b. DATE MAR. 18 1968		23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEM.		23d. LOCATION (City or Town) COLEMAR MANOR MD.		(County) (State)	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles J. Chambers</i>		DATE MAR 22 1968	



FOR STATE
HEALTH

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department
of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	26 HOUR
		<i>EZRA</i>		<i>FISHER</i>	<i>March 30 1968</i>			<i>M</i>	
3 SEX	4. RACE	S. DATE OF BIRTH	6 AGE (In years less birthday) YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN		
<i>M</i>	<i>W</i>	<i>May 25 96</i>	<i>11</i>						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD Month Day Year	
<i>New York City USA</i>				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Prince Georges</i>		<i>Mar 30</i>	<i>1968</i>
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Cheverly</i>		<i>Prince Georges General Hospital</i>		<i>Salesman</i>		<i>Real Estate</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE		13b. CITY OR TOWN		13d. INSIDE CITY & MTS?		13e. STREET AND NUMBER			
<i>NY Monroe</i>		<i>Montgomery</i>		<input checked="" type="checkbox"/> NO		<i>2290 St Paul Blvd</i>			
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last							
<i>Lewis M Fisher</i>		<i>Rochel Karmensker</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
<i>YES</i>		<i>109-36-4167</i>		<i>Son Milton Fisher - same</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Coronary Thromboses</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
						<i>10 min</i>			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF					
				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
4701 Stomach ulcers									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion	
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>	
ACTUAL SIGNATURE		<i>Dayton J. Watkins</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)		<i>DAYTON J. WATKINS</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<i>3-30-68</i>	
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County) (State)	
<i>Burial</i>		<i>4/1/68</i>		<i>HT HOPE CEM.</i>		<i>Rochester</i>			
24 FINERAL DIRECTOR				ADDRESS <i>4217-9th</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
GOLDBERG FUNERAL HOME		ST. MARYS		DATE <i>APR 2 1968</i>		Charles J. Charles Judge			



FOR STATE
HEALTH DEPT.

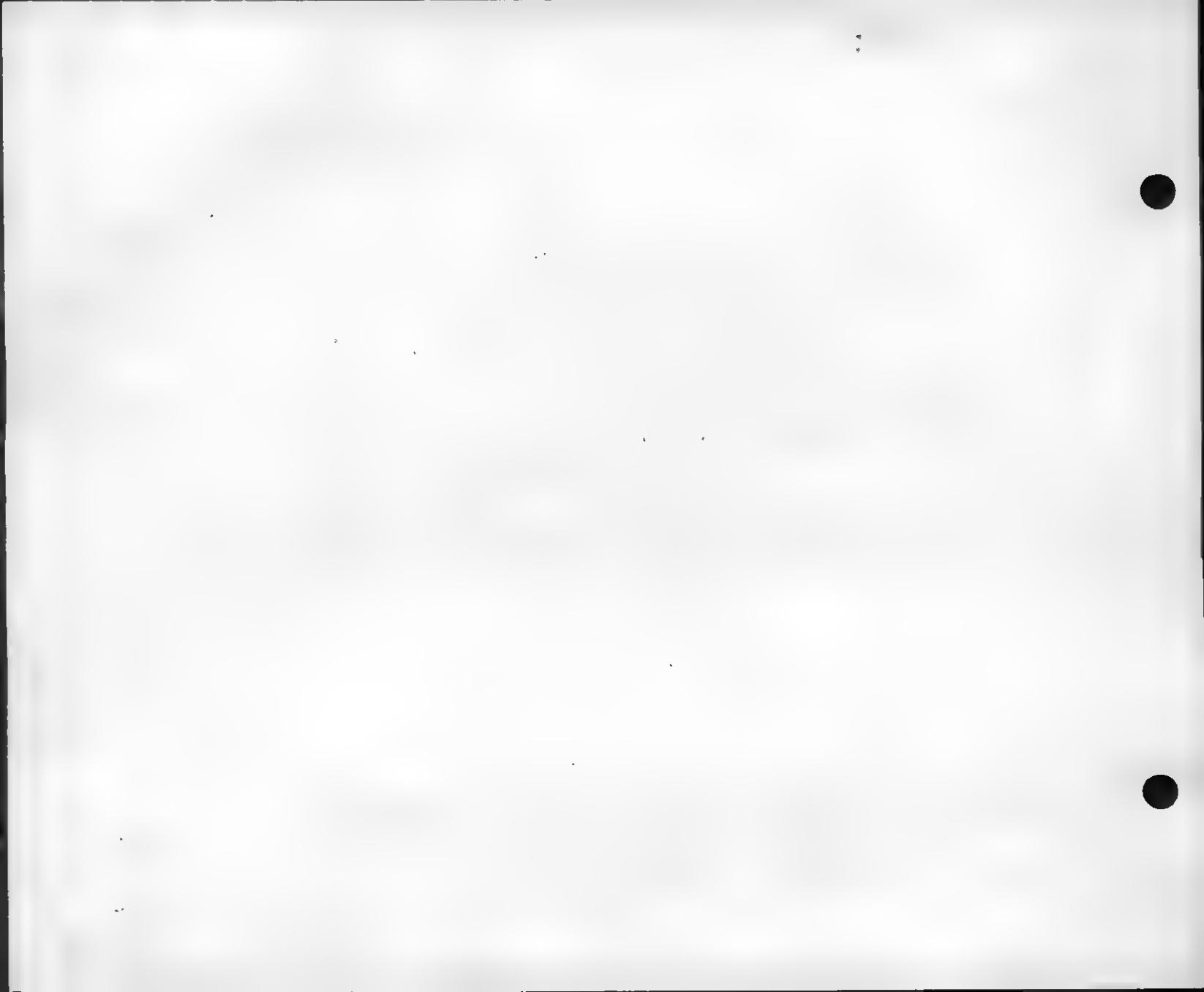
63
MAY 1968
RECEIVED
BY MAIL
TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First <i>Lisa</i>	Middle <i>Fletcher</i>	Last	2a DATE KNOWN OF DEATH ESTIMATED MATERIAL	Month 3	Day 18	Year 1968	2b HOUR 8:30a.m.
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH 3-10-1962	6 AGE (in years lost birthday) 6	7 MONTHS YRS	IF UNDER 1 YEAR MONTHS	IF OVER 24 HRS DAYS	HOURS	MIN	
7a BIRTHPLACE (State or foreign country) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>Maryland</i>		8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	W DIVORCED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month 3
10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince George Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived admission) STATE <i>Maryland</i>		13b COUNTY <i>Prince George's Capitol Heights</i>		13c CITY OR TOWN <i>Prince George's Capitol Heights</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <i>103 61st. Place</i>			
14 FATHER'S NAME <i>Louis Bernard Fletcher</i>	First	Middle	Last	15 MOTHER'S MAIDEN NAME <i>Barbara Jean Hawkins</i>	First	Middle	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT <i>Louis Bernard Fletcher - Father</i>		ADDRESS			
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Irreversible brain damage</u> DUE TO, OR AS A CONSEQUENCE OF <u>Anoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to inhalation of smoke</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 10:55am 3-13-1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) <i>Trapped in house fire</i>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>home</i>		21f. LOCATION Street or R.F.D. No City or Town County State <i>same as # 13</i>					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									22b. DATE SIGNED <i>3-18-68</i>
ACTUAL SIGNATURE <i>Jsh Kehoe</i>		EXAMINER'S NAME (Type) <i>John Kehoe MD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county) <i>Riverdale, Md.</i>					
23a BURIAL/CREMATION, REMOVAL, (Specify)		23b DATE <i>3-23-68</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Mt. Calvary</i>		23d LOCATION (City or Town) <i>Forestville Md</i>			(County) (State)
24 FUNERAL DIRECTOR <i>H. Washington & Sons 4925 Beale Ave</i>		ADDRESS <i>NE</i>		25a RECEIVED BY DIRECTOR <i>MAR 27 1968</i>		REGISTRATION SIGNATURE <i>James J. Judge</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MADE <input checked="" type="checkbox"/> Month Day Year 2b. HOJR						
Shelaline		Jeane	Fletcher		3-13-68 19 12 15pm						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS HOURS MIN	7c. DATE PRONONCED DEAD Month Day Year						
Female	Negro	5-27-65	2 YRS		2d. HOUR 3 13 68 12 15pm M						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.						
Md.		U.S.A.									
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Maryland		13a. USUAL RESIDENCE (Where deceased lived, if institution: Reside before admission) STATE Maryland		13c. CITY OR TOWN Prince George	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 103 (1st. Place					
14. FATHER'S NAME Louis B. Fletcher		First	Middle	Lost	15. MOTHER'S MAIDEN NAME Barbara Jean Hawkins		Middle	Lost	ADDRESS 7818 Harley Lane William E. Fletcher-Forestville, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO —		17. INFORMANT William E. Fletcher-Forestville, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Smoke inhalation DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 916.0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year HOUR A.M. 10:55 AM 3-13-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) trapped in house fire							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State same as # 13							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-14-68			
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE 3-18-68		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cath. Ch. Forestville		23d. LOCATION (City or Town) (County) P. 600, Md.					
24. FUNERAL DIRECTOR <i>Henry J. Washington & Sons - Deane Co., Inc.</i>		ADDRESS 44925		25a. REC'D BY REGISTRAR DATE MAR 19 1968		25b. REGISTRAR'S SIGNATURE <i>Henry J. Washington & Sons - Deane Co., Inc.</i>					



4
34573

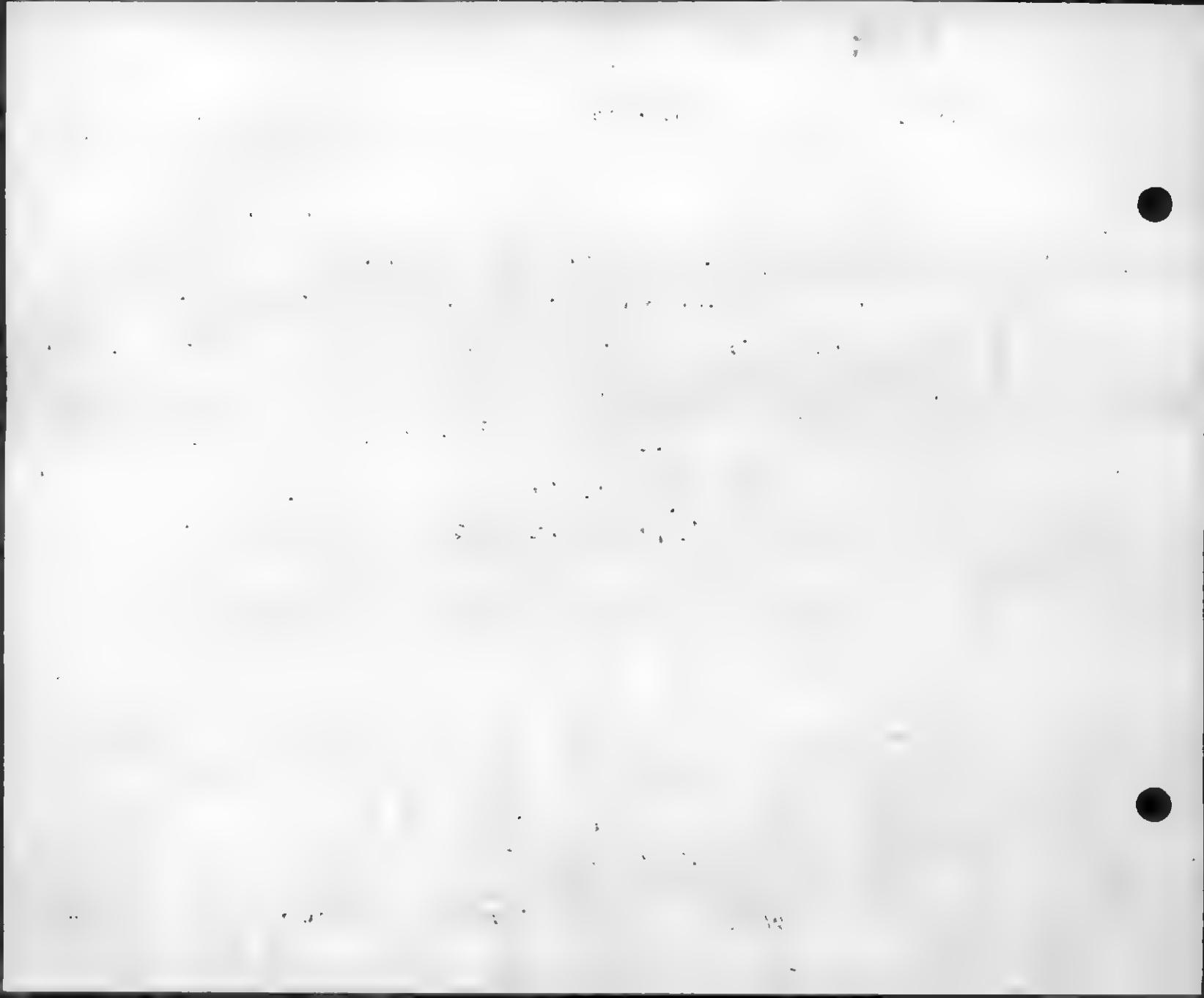
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Hanora (Hallie) Catherine Ford			2a. DATE OF DEATH Month 3 Day 1 Year 68			2b. HOUR A 4:35 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/31/82		6. AGE (In years last birthday) 80 85 RS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CIT.ZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) R.N.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN College Pk		13d. INSIDE CITY, LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Patrick		Middle J.		Last Carroll		15. MOTHER'S MAIDEN NAME First Sue	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 229-28-5707		17. INFORMANT Daughter		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<i>Cardiovascular Collapse</i>					
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Insufficiency</i> 2-6 mos. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular Disease</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>47</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from 1-27 , 19 68 , to 3-1 , 19 68 , that (I) (we) last saw the deceased alive on 3-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alfred R. Laper</i>		DEGREE ATTENDING PHYS		22c. MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>Bladensburg, Maryland</i>	
22d. PHYSICIAN'S NAME (Type) <i>Alfred R. Laper</i>		22e. ADDRESS <i>Bladensburg, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/4/68		23c. NAME OF CEMETERY OR CREMATORIAL Riverview		23d. LOCATION (City or Town) Richmond (County) Virginia (State)	
24. FUNERAL DIRECTOR <i>D.O. Williams J.J. Maloney</i>		ADDRESS 120		25a. REC'D BY REGISTRAR Charles George		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary. Please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN <input type="checkbox"/> Month Day Year			2b HOUR		
Samuel			Irvin	Forsht	Sr.	3-9-68			19 10:00am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			2c DATE PRONOUNCED DEAD Month Day Year			2d HOJR	
Male	White	10 Sept. 1887	80 yrs				3 9 68 19 10:30am				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.	
Pennsylvania		USA				Prince George's					
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-U. S. Govt.			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before address) Maryland			13c CITY OR TOWN Prince George's			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER Rt. 1, Box 233		
14. FATHER'S NAME Samuel I. Forsht			15. MOTHER'S MAIDEN NAME Annie Bailey								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO			17 INFORMANT Mary E. Forsht--Accokeek,			ADDRESS Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) And Mycosis fungoides			DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease						over 2 yrs.		
			DUE TO, OR AS A CONSEQUENCE OF						over 2 yrs.		
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3-10-68		
EXAMINER'S NAME (Type) John Kehoe MD			23c NAME OF CEMETERY OR CREMATORIALy			M.D. ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 3-12-1968			23d LOCATION (City or Town) Suitland, Maryland			(County) (State)		
24 FUNERAL DIRECTOR Simmons Bros.			ADDRESS Wash DC SIMMONS BROS. 1661-Good Hope Rd SE			25a REC'D BY REGISTRAR DATE MAR 12 1968			25b REGISTRAR'S SIGNATURE Charles Judge		

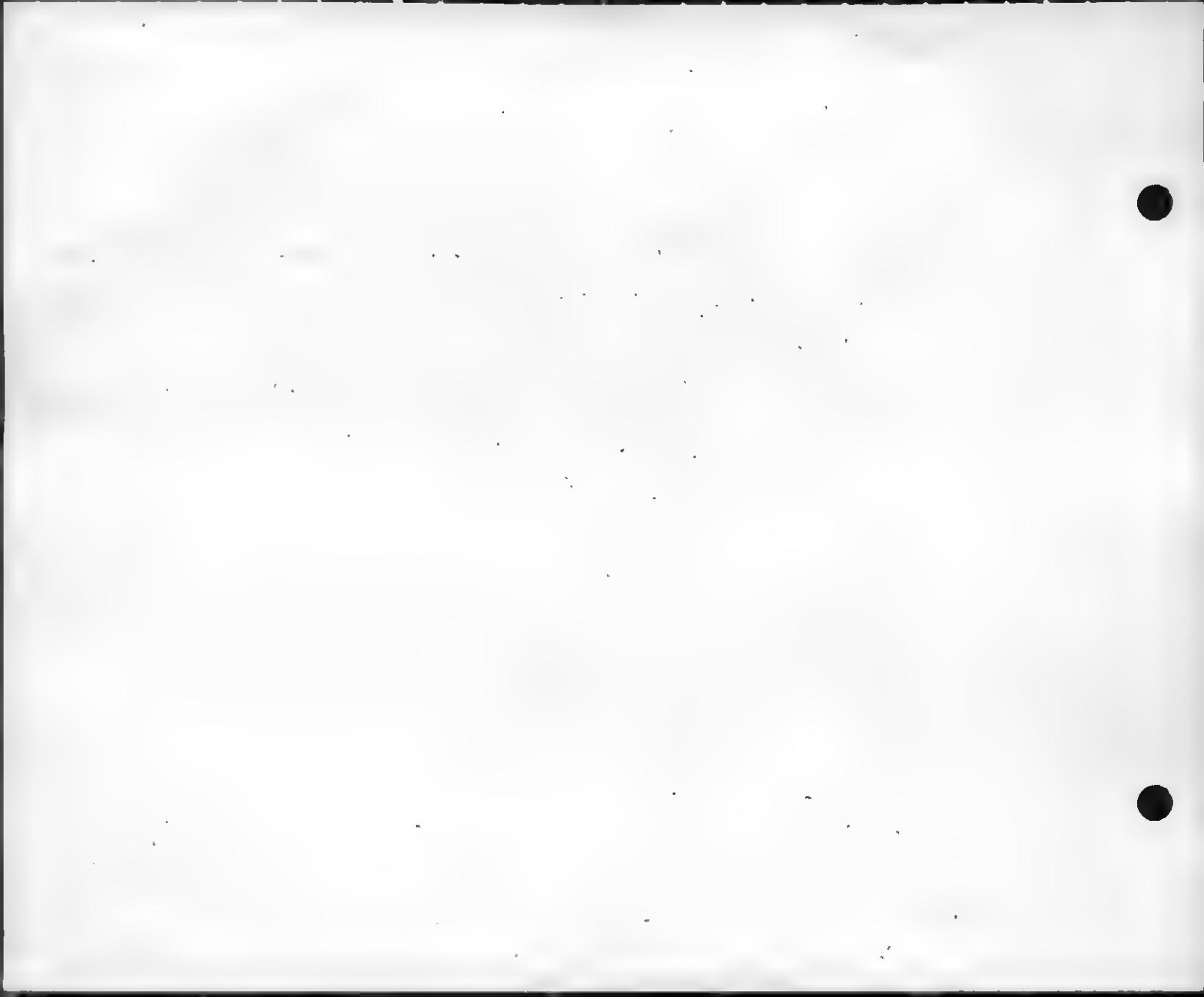


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.
2 **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician,
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2
 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

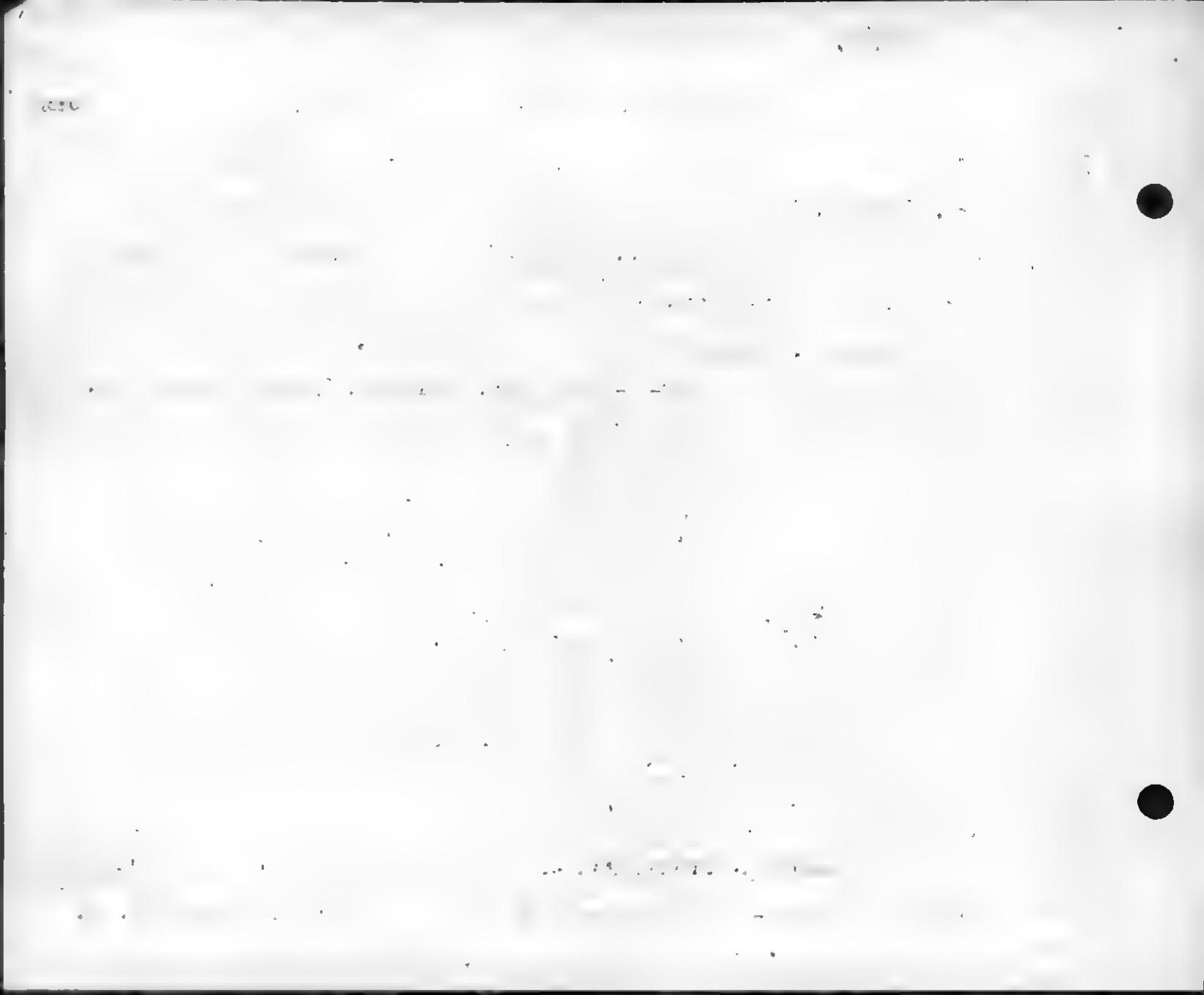
1 DECEASED NAME (Type or print)		First <i>Clara</i>	Middle <i>L.</i>	Last <i>Gaines</i>	2a DATE OF DEATH Month <i>March</i>	Day <i>16</i>	Year <i>1968</i>	2b HOUR <i>5 p.m.</i>	
3. SEX <i>Female</i>	4 RACE <i>White</i>			S. DATE OF BIRTH <i>07-25-83</i>	6 AGE (In years last birthday) <i>84 yrs.</i>	7 IF UNDER MONTHS <i>0</i>	YEAR <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	MIN <i>0</i>
7a BIRTHPLACE (State or foreign country) <i>Va</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Prince George's</i>					
10 CITY OR TOWN OF DEATH <i>Cheverly</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince George's General</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>own home</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>617 Beacon Rd.</i>				
14 FATHER'S NAME First <i>Francis M Evans</i>	Middle	Last	15 MOTHER'S MAIDEN NAME First Middle <i>Unknown</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>578 20 3058</i>	17 INFORMANT <i>Wm M Gaines</i>		Address <i>Bladensburg, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>4/22/68</i>									
(b) <i>Arteriosclerotic cardiovascular disease</i> DO TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive heart failure</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<input type="checkbox"/> MEDICAL CERTIFICATION					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 18, 1968</i> , to <i>March 16, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. Deitz</i>		DEGREE <i>MD</i>	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>3/17/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. Deitz</i>		22e. ADDRESS <i>Pro Geo Plaza Hyattsville, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 19, 1968</i>	23c. NAME OF CEMETERY OR Crematory <i>Cedar Wood Cemetery</i>		23d. LOCATION (City or Town) <i>Edinburg</i>	(County)	(State)		<i>Va</i>
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Marshall	Middle Thomas	Last Gaither	2a DATE OF DEATH Month March	Year 1968	2b HOUR A.M. 10:50	
3 SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 5/12/1996			6 AGE (In years last birthday) 56	IF UNDER 1 YEAR MONTHS YRS.	F. UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Mont. Laytonsville Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges			Md		
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Farming			12b KIND OF BUSINESS OR INDUSTRY Farm	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b COUNTY Prince Georges	13c CITY OR TOWN Clinton	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER 7901 Stewart Lane				
14. FATHER'S NAME First George	Middle E.	Last Gaither	15. MOTHER'S MAIDEN NAME First Olivia Layton			Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (Type give war or dates of service) 212-15-8206	17 INFORMANT Mrs. William E. Gaither			Address Wheaton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Anoxemia								
DUE TO, OR AS A CONSEQUENCE OF High output renal failure								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>during and never repair evulsion plus GI bleeding</i>								
19a. DATE OF OPERATION 3-18-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Benign prostate hypertrophy			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING CAUSE OF INJURY <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. P.M.	MONTH March	DAY 19	21b. INJURY OCCURRED AFTER Nature of injury in Part 1 or Part 2, Item 18.) Right eye			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Feb. 24, 1968 to March 19, 1968 , that (I) (we) last saw the deceased alive on March 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE <i>Manuel V. Penasales</i>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> AGREE <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	DATE SIGNED 3-20-68	
22d. PHYSICIAN'S NAME (Type) Manuel V. Penasales, M. D.		22e. ADDRESS Prince Georges General Hospital, Cheverly,						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 3-21-68	23c NAME OF CEMETERY OR CREMATORIAL Laytonsville			23d LOCATION (City or Town) Laytonsville	(County) Mont. Md.		
24 FUNERAL DIRECTOR FRANCIS H. BARBER	ADDRESS LAYTONSVILLE			25a. REC'D BY REGISTRAR MAR 26 1968	25b. REGISTRAR'S SIGNATURE <i>Jane Juges</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18 G ve Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b. HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE, in years last birthday	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	9 IF UNDER 24 HRS MIN					
Female	White	April 4, 1880	87 yrs								
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH	2c DATE PRONOUNCED DEAD Month 3 Day 17 Year 68 19 3:00pm M				
Penn.		USA				Prince George's Md.	2d. HOUR				
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland			13c CITY OR TOWN Prince George Hyattsville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4. 05 69th. Place				
14 FATHER'S NAME Miller			15 MOTHER'S MAIDEN NAME UNK								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no			16b. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT Mr. Paulin (Funeral Dir) Reading, Penna					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH inu'cs	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 5 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4200			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
MEDICAL CERTIFICATE BY			19c TIME OF INJURY Month, Day, Year PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.
ACTUAL SIGNATURE 											ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.											ADDRESS (Street, city, town, or county) Reading, Penna.
23a. BURIAL, CREMATION, REMOVAL (Check)			23b. DATE 3/19/68			23c. NAME OF CEMETERY OR CREMATORIAL Park Forest Hills Memorial			23d. LOCATION (City or Town) (County) (State) Reading, Penna.		
Burial Removal											
24 FUNERAL DIRECTOR Jos. Gawler's Sons			ADDRESS 5130 Wisconsin Av., NW Wash. D.C.			25a. REC'D BY REGISTRAR DATE MAR 21 1968			25b. REC'D BY SIGNATURE 		



FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04570

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> March 17, 1968 2b. HOUR 2:30A M
Baby Boy		Garner			
3. SEX male	4. RACE negro	5. DATE OF BIRTH 3/17/68	6. AGE (in years last birthday) — yrs.	IF UNDER 1 YEAR <input type="checkbox"/> MONTHS DAYS HOURS MIN. 1hr.	2c. DATE PRONOUNCED DEAD Month Day Year March 17, 1968 2:50A
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Prince Georges Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2802 Forest Terraces
14. FATHER'S NAME Robert		Middle Junior Butler	Last	15. MOTHER'S MAIDEN NAME Margaret	Middle Louise Garner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Mother same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> APPROX 6 mo. 500 gcm. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 776X					
19a. DATE OF OPERATION MAY 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3-19-68	
EXAMINER'S NAME (Type) John Kehoe		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (specify)		23b. DATE 3/23/68		23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo General Hosp.	
24. FUNERAL DIRECTOR SHIRLEY W. PENN, JR., ADMINISTRATOR		ADDRESS		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland	
				25a. RECD BY REGISTRAR DATE MAR 27 1968	
				25b. REGISTRAR'S SIGNATURE <i>J. Shirley Judge</i>	

Item 13 film 398 3-14-68 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04577

CERTIFICATE OF DEATH

04577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file in b the terminal director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First EDWINA	Middle GONZALES	Lost	2a. DATE OF DEATH MAR 2 Day 68 Year	2b. HOUR 2005 M
3. SEX FEMALE	4. RACE CAUCASIAN	S. DATE OF BIRTH 3 OCT 40	6. AGE (In years lost birthday) 27 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country) NEW MEXICO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGE'S	Md.	
10. CITY OR TOWN OF DEATH ANDREWS AFB	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASH. D.C. Md.	13b. COUNTY D.C. Fr. Geo.	13c. CITY OR TOWN WASH. D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2444 ROCHELLE AVE.	
14. FATHER'S NAME ERMINIO	First MIDDLE GUTIERREZ	15. MOTHER'S MAIDEN NAME CLARINDA	Middle JARAMILLO	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 525-84-7087	17. INFORMANT SGT ELIZARDO GONZALES	Address SAME AS ITFM #13	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA & SEPTICEMIA 734.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) SYSTEMIC LUPUS ERYTHEMATOSUS DUE TO, OR AS A CONSEQUENCE OF (c) 456x					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) LEUKOPENIA AND THROMBOCYTOPENIA					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5 Feb 1968, to 2 Mar 1968, that <input type="checkbox"/> (we) last saw the deceased alive on 2 Mar 1968, and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Burton Sack	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 2 Mar 68	
22d. PHYSICIAN'S NAME (Type) BURTON SACK, CAPT USAF MC	22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/8/68	23c. NAME OF CEMETERY OR CREMATORIAL Sedillo Cemetery	23d. LOCATION (City or Town) Bernalillo	(County) County	(State) New Mexico
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland	ADDRESS 4308 Suitland Road, Suitland, Maryland	25a. REC'D BY REGISTRAR MAR 8 1968	25b. REGISTRAR'S SIGNATURE Charles Young		

10000

MAZARATI

PIRELLA

FERRARI

PIRELLA
FERRARI